Child Death Reviews and Child Mortality Data Collection in Canada

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EXECUTIVE SUMMARY

At present, there are no comprehensive Canadian statistics on the incidence of child abuse and neglect deaths. In conducting research into child abuse and neglect fatalities, it became obvious that definition is both a critical factor for success and a current barrier to accurate counting of child maltreatment deaths in Canada. Efforts in the USA have had similar results as there are 50 states counting fatalities in ways that are sufficiently different to make a national count a difficult task.

Canada's twelve Chief Coroners and Chief Medical Examiners meet yearly to consider these and other issues with respect to their own work. The twelve Directors of Child Welfare in Canada also have regular meetings to discuss issues of common interest. The provincial Child Advocates in Canada also have regular contact around issues of policy and practice. These systems, plus the existence of a national organization of Chiefs of Police, offers hope that Canadians may be able to work together to arrive at an accurate count of the number of Canadian children who die each year from acts of commission or omission by those adults responsible for their well-being. This research is intended to support a better understanding of how child deaths are investigated and counted across Canada. Part of this involved understanding what information is collected by police, Chief Coroners and Chief Medical Examiners, Child Advocates and child welfare at the provincial or territorial level. A survey using a purposive sampling method was chosen as the way to obtain a "picture" of how the deaths of children are dealt with across the country. Interviews with key informants were planned as a means of getting greater detail about the process of dealing with child deaths.

An area chosen for investigation was the use and composition of child death review teams in Canada. These "teams" have been in use for twenty years in the USA and have proven so valuable in ensuring that maltreatment deaths are not misunderstood that their use has spread to Canada and elsewhere. Currently, there are eight such teams in Canada, each with its own unique characteristics designed to provide the best fit with provincial or territorial legislation, population and the needs of each area. The oldest of these teams is only six years old and two of the eight were formed in 1998. An examination of these teams, including their composition and function, was included in the research plan.

A lack of common definitions proved to be a barrier in efforts to obtain information about neglect deaths. Some systems found the term offensive, describing it as pejorative. Others collected information about neglect but database limitations made it difficult to retrieve it once it was entered into a file. With few exceptions, the systems surveyed collected and stored a large amount of valuable information on child deaths but technical barriers such as different database structures made the comparing of information difficult if not impossible. The greatest hope lies in the use of "extractable data elements" that would be defined and described using agreed upon terms to enable the collection of child death data on a national level. With few exceptions, willingness to do this was evident—even the exceptions arose more from scarce resources than from a belief that there was no point in conducting research into child maltreatment deaths.

II INTRODUCTION

The Problem

The death of a child from a preventable cause is a tragic event. When that cause is child abuse or neglect, the public expects that efforts will be made to reduce such deaths. Governments and law enforcement agencies often receive much of the pressure to reduce child maltreatment fatalities. However, prevention efforts require that the scope and complexity of the problem be understood first.

There are no adequate Canadian statistics on the incidence of child abuse and neglect (CAN) deaths. The recognition of the lack of such data was instrumental in the formation of a federal-provincial/territorial working group on child and family services information. (Federal-Provincial Working Group on Child and Family Services Information, 1994) It is possible to obtain fairly accurate information on how many children die as a result of physical abuse including the cause of death and the relationship of the perpetrator to the child if the death is classified as a homicide. However, there are no national statistics on deaths due to child neglect. (Karen Rogers, Canadian Centre for Justice Statistics, personal communication, June 19, 1995) It is believed that efforts to prevent child maltreatment deaths are hampered, in part, by dissimilar child abuse classification systems that prevent the sharing of information between provinces and territories. Without a uniform, national inter provincial and territorial classification system, data cannot be compared and accurate analysis regarding CAN deaths on a national level cannot occur. At the present time, the types of data collected and reviewed in classifying child deaths vary, as a result of a lack of national standards for child death investigations.

The Project

What is the Child Mortality Analysis Project?

Current child death data collection practices used in Canada may discourage child deaths due to maltreatment from being captured as such. The Child Maltreatment Division of Health Canada's Bureau of Reproductive and Child Health has funded this research to examine this problem. The Child Mortality Analysis Project consists of three sections. First, the existing data collection procedures, techniques and practices utilized by the various professions who intervene in cases of child death (with a focus on those cases where maltreatment is suspected or substantiated) will be examined. The next step will be to conduct a comparative analysis of these practices. With the results of these two parts of the project in mind, the third activity will be to develop (for the use of Health Canada) recommendations related to multidisciplinary child death review teams and child mortality data collection.

What are the Goals and Objectives of the Project?

The goals of the Project are:

- To contribute to a better understanding of how data relating to child deaths are captured
- To develop a model to help inform multidisciplinary responses to child deaths.

The objectives of the Project are:

- To examine how child deaths are classified in Canada
- To document the obstacles to child mortality data collection
- To furnish a description of the

procedures, techniques and practices that would facilitate better identification, classification and data capture of the incidence of child mortality.

- To provide recommendations regarding the advisability and feasibility of improved national child mortality data collection.
- To provide policy and operational insights for stakeholders involved with the issue of responding to child deaths.
- To better understand the role of selected disciplines in responding to child deaths (e.g. child protection, social work, forensic science, medicine and child mental health)

How Will the Information Be Used?

A range of professions concerned with the issue of child death will be targeted with this information including law enforcement, Crown Attorneys, child protection, mental health, medicine, public health, forensic science, policy and program analysis and the judiciary.

Who Is Involved in the Project?

The project is being undertaken by Jan Christianson-Wood, a social worker and Special Investigator in the Office of the Chief Medical Examiner of Manitoba, and Jane Lothian Murray, an Instructor and researcher at the University of Winnipeg. A multidisciplinary project advisory committee was formed to provide advice on the project. (See Appendix A)

III AN OVERVIEW OF RESEARCH ON CHILDMALTREATMENT DEATHS IN CANADA

National statistics on child deaths due to injuries are available from a variety of sources, however these collection systems are limited in their ability to produce data that is useful in assessing the issues surrounding child maltreatment death.

Canadian Data and Research on Child Deaths

The History of CAN Death Research in Canada

Over 15 years ago, Corinne Robertshaw, a Canadian lawyer, undertook research on child abuse and neglect deaths in Canada with the assistance of Health Canada and published a study on child death identifying the lack of reliable information on incidence rates as a major concern. Through this study, she estimated the national incidence of abuse and neglect deaths in 1977. However, a lack of common definitions of child abuse and neglect between provinces and territories, the misclassification of child deaths and the absence of data for Quebec and Saskatchewan made accurate national statistics on the incidence of child abuse and neglect fatalities in Canada impossible. Robertshaw's work is important because of the efforts that were made to collect and analyze information from different systems such as child welfare, health (including mental health) and law enforcement.

Classification issues were central to Robertshaw's study. The provincial child protection registries listed only 29 (54%) of the deaths studied as child maltreatment deaths. She concluded that the expertise of the coroner or medical examiner and the pathologist is crucial in determining (as it still does now)

whether or not the death is accurately classified. Robertshaw was clear that her initial estimate did not account for unreported, misdiagnosed or misclassified deaths. She concluded that the actual incidence of child maltreatment deaths was probably much higher considering that "5% of all deaths to children under 5 years of age that [were] classified as accidents (excluding transportation accidents) and symptoms and ill-defined conditions [were], in fact, caused or substantially contributed to by abuse or severe neglect." (Robertshaw, 1981)

Nearly ten years later, Cyril Greenland (1987) examined 10 years of child abuse and neglect fatalities in Ontario (1973-1982); a total of 100 cases. Classification issues also played a significant role in this study. The child abuse and neglect deaths in the study sample were included in Ontario's Vital Statistics as 'accidental and violent deaths' rather than being defined as separate categories. To analyze these deaths, Greenland created a typology of CAN deaths that included the following five categories: 'battered child syndrome', 'neglect or acts of omission', 'homicide or impulsive criminal acts', 'discipline and inappropriate handling...of an otherwise well-cared-for infant' and 'Other Unclassified'. These categories were a combination of the manner of death (homicide) and the circumstances of death (battered child syndrome, discipline and neglect). Several categories, including homicide, battered child syndrome and discipline, overlapped with respect to the use of force or violence against the child. Greenland described the overlap as 'inevitable' with 'each of the categories [having] some unique features'. (Greenland, 1987) A major problem with Greenland's classification system was the lack of unique criteria distinguishing one category from another. (Christianson-Wood, 1995)

Ontario Child Mortality Task Force Final Report

In 1995, the Chief Coroner of Ontario and the Ontario Association of Children's Aid Societies identified a need to address the problem of children who die while receiving child welfare services. However, researchers investigating this phenomenon found themselves unable to find any information about the exact number of children who die in these circumstances. With no data and no consistent review of child deaths, it was impossible to understand the extent of the problem. Consequently, strategies aimed at better methods of prevention, intervention and care of vulnerable children could not be developed. In April of 1996, the Office of the Coroner for the Province of Ontario and the Ontario Association of Children's Aid Societies, with support from the Ministry of Community and Social Services established the Ontario Child Mortality Task Force (OCMTF). This Task Force was created to undertake a review of the children who had died while receiving child welfare services during the two-year period from January 1, 1994 to December 31, 1995. This comprehensive review involved all 55 Children's Aid Societies in Ontario and spanned 14 months. In addition to conducting a survey about the children who died, the Child Mortality Task Force examined data collection, information sharing and education issues. The Task Force published their findings in an Interim Report in March 1997 and a final report in July 1997. A progress report on the recommendations was published in April 1998.

The Gove Report & The British Columbia Children's Commission

The Gove Report was the outcome of an independent commission of inquiry into the adequacy of the services, policies and practices

of the British Columbia Ministry of Social Services as they related to the apparent neglect, abuse and death of Matthew John Vandreuil. The inquiry was originally announced in May 1994, by the Honourable Joy MacPhail, Minister of Social Services and began shortly thereafter. The process was divided into two parts. Judge Gove's description of the inquiry process is found in the Letter of Transmittal at the beginning of Volume One: Matthew's Story.

> During Part 1, I would hear evidence from those who had been involved with Matthew and his family, those who took part in the Superintendent's Review and those who were the ministry's senior managers responsible for child protection policy and management of child protection services. During Part 2, I would hear from the public and I would meet with many people, including youth who are or who had grown up in the care of the ministry, social workers, senior government officials, labour leaders, associations of foster parents, community organizations and groups representing parents and grandparents. I would seek solutions to the systemic problems that marked Matthew's tragic life and led to his death. (Gove, 1995)

Justice Gove's final report was published in 1995, after the commission spent nearly 18 months examining how British Columbia's children were protected from abuse and neglect. It explored how child protection services were delivered, what quality assurance measures existed and needed to be developed, the qualifications and training of social workers, and the impact of new provincial child protection legislation. It concluded with recommendations for the design and operation of a new child-centred child welfare system.

After accepting the report of the Gove Commission, the Government of British Columbia created the Children's Commission, with a mandate to review all child deaths in the province and investigate those where circumstances warranted. "All deaths of children in care of the government, as well as natural deaths of interest from the perspective of examining child serving systems and public health and safety issues are also investigated." The Children's Commissioner described the system as one that allowed the Commission to analyze the causes of all child deaths and any concerns about services the child received while living. The Commission is also able to identify agencies and ministries that have done an exemplary job in serving a child and provide this information as a model for other organizations. This information is used to provide immediate feedback to agencies and ministries so that immediate changes can be made when practice issues are identified. (http://www.childservices.gov.bc.ca/work/investprocess.html)

The first annual report published by the Children's Commission was released in February 1998. This document provides a summary of the completed fatality reviews. It also discusses important matters surrounding the investigation of fatalities including integrated case management, information sharing and the training of service providers.

Canadian Incidence Study of Reported Child Abuse and Neglect

The Canadian Incidence Study of Reported Child Abuse and Neglect (CIS) utilizes a multistage cluster-sampling methodology to collect data describing the scope of the problem of reported child abuse and neglect. The data collection is limited to child welfare agencies, with data collected directly by the investigating child welfare

workers. The researchers designated a three-month collection period ending in the spring of 1999 that involved randomly selected child welfare agencies across the country. To ensure that data collection was consistent across sites, standardized CIS operational definitions were used to determine which cases were included as maltreatment investigations. (Phaneuf and Tonmyr, 1998)

The analysis of data collected will include:

- Incidence rates of abuse and neglect by form(s) of maltreatment;
- Characteristics of maltreatment such as nature of harm, severity of harm, duration of maltreatment, perpetrator characteristics, use of physical punishment/discipline;
- Characteristics of child and family such as age, gender, family structure, parental risk factors.
- Selected key determinants of health including personal coping practices, ethnicity, social support, housing and income.
- Investigation outcomes such as police involvement, criminal charges, court involvement, placement and case status.

While the incidence study is designed to generate national estimates of child abuse and neglect, it will also register any child deaths reported to one of the sites during the data collection period.

Injury Statistics and Injury Prevention Research

Health Canada

Health Canada provides fact-sheets prepared by the Canadian Institute of Child Health on the cause of injury deaths using Statistics Canada hospital micro-data files. This information includes a breakdown of the major causes of injury deaths by age group and sex, on both a national and provincial level. It should be noted that although a number deaths from burns, drowning and falls involve neglectful parenting, it is not possible in examining this data to distinguish these injury deaths from those that occur despite adequate parenting and supervision.

Deaths as a result of striking a child are tabulated separately from homicides. Homicide data are given, but there is no indication in these fact sheets of how many deaths are due to maltreatment. (www.hc-sc.gc.ca/main/hppb/cny/factsheets/All_injuries) Other infomation can be found at sites for child and youth health issues. (www.hc-sc.gc.ca/hppb/childhood-youth/cyfh/factsheets/factsheets.htm).

Canadian Hospitals Injury Reporting and Prevention Program

Health Canada addressed the gap in knowledge surrounding child injury by establishing the Canadian Hospitals Injury Reporting and Prevention Program (CHIRPP) in 1989. This program is a coordinated approach to collecting nation-wide data on the circumstances of all types of childhood injuries. CHIRPP collects and analyses data on injuries and poisonings from the emergency departments of 16 hospitals across Canada through a computerized information system. The cumulative national database resides in Ottawa at Health Canada's Bureau of Reproductive and Child Health. For each case data entry clerks code information on more than 40 variables and write a single line of text describing "what happened" based on the account provided by the parent or patient. The result is a unique, richly detailed database. The "pre-event" information collected by CHIRPP is not available anywhere else. (www.hc-sc.gc.ca/main/lcdc/web/brch/injury/chrpa.html)

CHIRPP provides reports on a variety of injuries, including playground equipment, baby walkers, cribs, cradles and bassinets, falls from or by shopping carts, garage doors, strollers and carriages. Although this system was designed to protect children from unnecessary debilitating injuries and premature death, it has a major shortcoming related to identifying abuse and neglect related injuries. During hospital admission, the accompanying adult completes a one-page questionnaire about the injury incident. There is no investigation into the validity of these statements. The attending physician provides additional information regarding the nature of the injury, body part injured and treatment received. It is possible and probable that some injuries due to child abuse or neglect will be missed depending on how the attending physician classifies the child's presenting complaint while considering the injury scenario presented by the accompanying adult.

A recent publication of Health Canada, *For the Safety of Canadian Children and Youth: From Injury Data to Preventive Measures* (1997) provides an up to date view of a major health problem for Canadian children; injuries. In 1992, out of 4,838 deaths of Canadians under the age of 20, 1,542 were the result of injuries. Comparing this to the 310 deaths nationally due to cancer and the 113 due to infectious diseases, the scope of the problem becomes clear.(Health Canada, 1997:2) Chapters focus on the various types of injuries, from motor vehicle injuries to those sustained when the young person was working. Homicide is also discussed, as are rates of abuse and neglect. However, rates of child deaths from neglect are not included, as there are, as yet, no reliable Canadian statistics on these deaths.

Statistics Canada

Statistics on homicide-related child deaths are available from Statistics Canada through two sources. These are the mortality database and the Homicide Survey database which is maintained by the Canadian Centre for Justice Statistics. The Statistics Canada mortality database collects information on child homicides obtained directly from death certificates and does not include ongoing police or coroner investigations. The Homicide Survey is more inclusive than the mortality database and records all incidents of homicide under investigation by police forces across Canada. The most recent statistics available through this source are 1991-1993. (Health Canada, 1997: 254) This database also provides more detailed information regarding the victim, the perpetrator, the victim-offender relationship, weapons used, and the circumstances surrounding the homicide.

The Homicide Survey reports that homicide rates are by far highest for infants, nearly five times the overall rate for children and youth under 20. In fact, homicide is the leading cause of injury-related death for infants. A reported 2/3 of murdered children are killed by a parent. Fatal injury in younger children most often results from beating or strangulation. The Homicide Survey further reported that the majority of young children are killed in private homes whereas older children and youth are more likely to be murdered in a public place usually outdoors. (Health Canada, 1997:255).

Injury Prevention Research

It is recognized that injuries are a predictable and preventable phenomenon. Canadian injury prevention research is taking place through Health Canada's CHIRPP and a variety of other provincial programs. For

example, the Alberta Centre for Injury Control and Research publishes an analysis of injury deaths and hospitalizations in the Alberta Injury Data Report. This report examines trends in injury rates for the province, and summarizes injuries for 40 causes of injury, breaking down the information by gender and different age groups and including detailed descriptions of injury causes. The Centre for Injury Control and Research also publishes a Directory of Alberta Injury Data Sources which provides a listing of routinely collected injury data sources in Alberta with contacts and descriptive information for each source. (http://www.med.ualberta.ca/acicr, 1998)

A number of Canadian universities perform injury research. For example, the research done by the Injury Research Group at the University of Alberta includes the development of leading-edge injury surveillance systems, development and evaluation of injury countermeasures, outcome research, cost analysis, and education of injury control professionals. (Alberta Centre for Injury Control and Research, 1998) A national study on the rates of injuries and strategies for prevention notes that children from low socio-economic groups are the most likely to suffer injury and to die from maltreatment. In considering the deaths of children from injuries, Canada's low rates of child homicide in comparison to the United States should not be taken for granted as it appears that higher rates of poverty and lower community living conditions play a role in U.S. child homicide rates. (Health Canada, 1997:263)

U.S. Research on Child Deaths

With limited national data on child abuse and neglect deaths, Canadian researchers in the past had relied primarily on reports from the United States, particularly in considering problems with classification and accurate capture of data. The United States has embarked on a number of national surveys and other large-scale projects in an attempt to understand its own national incidence of CAN deaths.

Child Maltreatment Fatalities Project

In 1991, the Child Maltreatment Fatalities Project, a joint effort of the American Bar Association (ABA) and the American Academy of Pediatrics (AAP) released a manual for the design and implementation of child fatality review teams and a book of recommendations on uniform data collection for child fatality review teams. These publications supported the expansion of review teams across the United States. A training package for review teams was also developed.

US Advisory Board on Child Abuse and Neglect

A Nation's Shame: Fatal Abuse and Neglect in the United States is the 1995 report by the US Advisory Board on Child Abuse and Neglect (US ABCAN). This fifth annual report was written to alert Americans to the increasing problem of child maltreatment fatalities. A number of national databases were studied for this report in an attempt to determine the incidence of child maltreatment deaths. However, no final analysis was possible due to the identification of chronic misclassification in these databases. In this report, the Board made 26 recommendations addressing such issues as improved case investigation, the need for a nation-wide system of child fatality review teams, and fatality prevention. (US ABCAN, 1995)

The Annual Fifty State Survey

The National Committee for Prevention of Child Abuse (NCPCA, 1992) attempts to collect detailed information from the fifty states and the District of Columbia on the number and characteristics of child abuse reports, the number of child abuse fatalities and changes in the funding and scope of child welfare services. Since 1986, NCPCA has published an annual report providing an analysis of their results including an estimate of the number of child abuse reports and child abuse fatalities nation-wide. Many difficulties have been encountered in analyzing responses where data is incomplete or incompatible. The 1992 survey reports that the estimate of child maltreatment fatalities is based on slightly less than 70% of the United States child population. Estimates for earlier years are based on at least 85% of the child population. One of the problems identified is that an increase in the reported fatality rate may not indicate an actual increase in incidence. Eight of the seventeen states that reported an increase in the fatality rate attributed the change to more accurate counting of fatalities. (NCPCA, 1992)

National Incidence Study

The National Incidence Study (NIS) is a congressionally mandated, periodic effort of the National Centre on Child Abuse and Neglect (NCCAN). The first NIS was conducted in 1979-1980 and published in 1981, the second conducted in 1986-1987, was published in 1988. The third and most recent NIS collected data in 1993-1994 and analysis was conducted in 1995-1996, with the results published in 1996.

A key objective of the NIS-3 was to provide updated estimates of incidence of child abuse and neglect in the United States and measure changes in incidence from earlier studies. This study included children known to child welfare agencies as well as children seen by community professionals, who were not reported to child protective services (CPS). Trained professionals gathered data over a period of three months. Since data has been consistently collected based on specific definitions of abuse and neglect, the results from the three NIS estimates provide a basis for comparison in identifying changes over time in the incidence and distribution of abused and neglected children. Due to limitations in the data collection process, this study is unable to attempt to establish the national incidence of maltreatment deaths. (Sedlack & Broadhurst, 1996)

IV THE CHILD MORTALITY ANALYSIS PROJECT

Research Design and Methodology

Two data collection instruments were used to generate information regarding the ways in which Canadian provinces and territories record information on child deaths from maltreatment: a mail survey and a semi-structured telephone interview. The survey was comprised of two parts. Part 1 of the survey included **process** questions related to how systems collect data relevant to child deaths and how the various systems respond to child deaths. Part 2 of the survey included questions pertaining to **data collection**; that is, specifically what information is collected in the case of child deaths. Seventy-nine surveys were sent to key informants representing four systems: Child Welfare, Chief Medical Examiner/Coroners, Child Advocates and Police. A total of 46 completed surveys were received resulting in a response rate of 57%.[1] This response is adequate for analysis and reporting. (Babbie, 1979)

Key informants were selected using a **purposive sampling** method, meaning that the informants were selected on the basis of the researchers' judgement about who would be the most knowledgeable in a particular system and jurisdiction. Key informants were sampled in each of the ten provinces and two territories. Responses were obtained from nine provinces and two territories.

All Child Advocates[2] responded to the survey request. Not all were able to complete surveys as their mandates did not give them a role in child death reviews at the provincial level.

A total of 38 follow-up interviews were conducted after a preliminary analysis of the survey response was complete. Given the resource and time constraints of the project, it was not possible to interview all of the survey informants although informants were contacted within each province or territory and system. The interviews were semi-structured to ensure that all relevant information was collected while at the same time allowing interviewees to elaborate as they felt necessary. The interview questions were developed after reviewing the survey responses. These interviews were used to:

a) Validate or confirm the information obtained from the surveys.

b) Clarify some of the ambiguous or unclear responses from the surveys.

c) Provide additional qualitative data that was not generated by the surveys.

Limitations of the Data:

i) Differntial Response from Child Welfare agencies The participation of provincial and territorial child welfare ministries or departments affected the completeness of the survey.

ii) Definitional Issues Given the sensitive nature of child deaths resulting from abuse and neglect, some topics were difficult to adequately capture with a survey. For example, some informants had difficulty with the concept of 'suspicious deaths'- and asked for clarification or definitions from the researchers. However, the reason for including a question about 'suspicious' child deaths was to collect information about how the informants defined this concept. The follow-up interviews proved to be extremely useful in addressing this limitation.

iii) Square Peg - Round Hole Issues In other words, a survey designed with selected responses such as Yes/No is not always able to capture the richness of the information available. Informants in some cases were unable to 'fit' their responses in the categories selected, and provided their own responses, which cannot be captured with quantitative analysis. However, the inclusion of some open-ended questions and the follow-up interviews were designed to address this limitation.

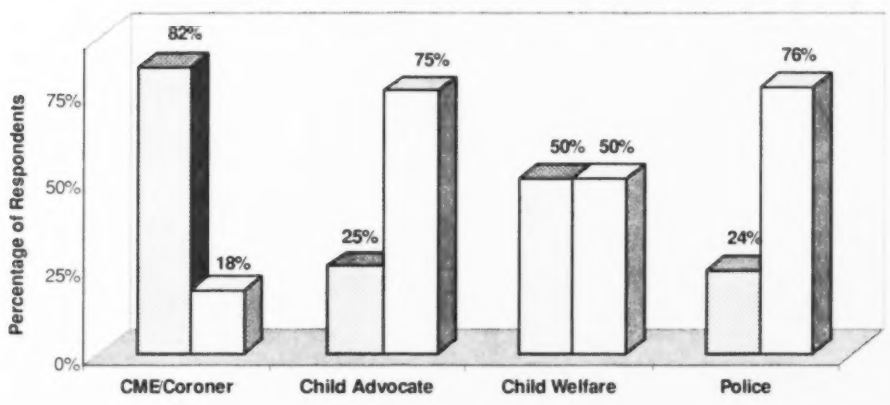
V FINDINGS AND DISCUSSION

PART 1 Data Management Systems

How Systems Collect Data Relevant to Child Deaths

The survey included several questions regarding the type of information each of the various information systems (Child Advocate, Child Welfare, Coroner/CME and Police) had about child deaths in their jurisdictions, and how this information was collected, stored, retrieved and shared with other systems. The results indicated that data management with

Figure 1 **Availability of 1996 Child Death Statistics**



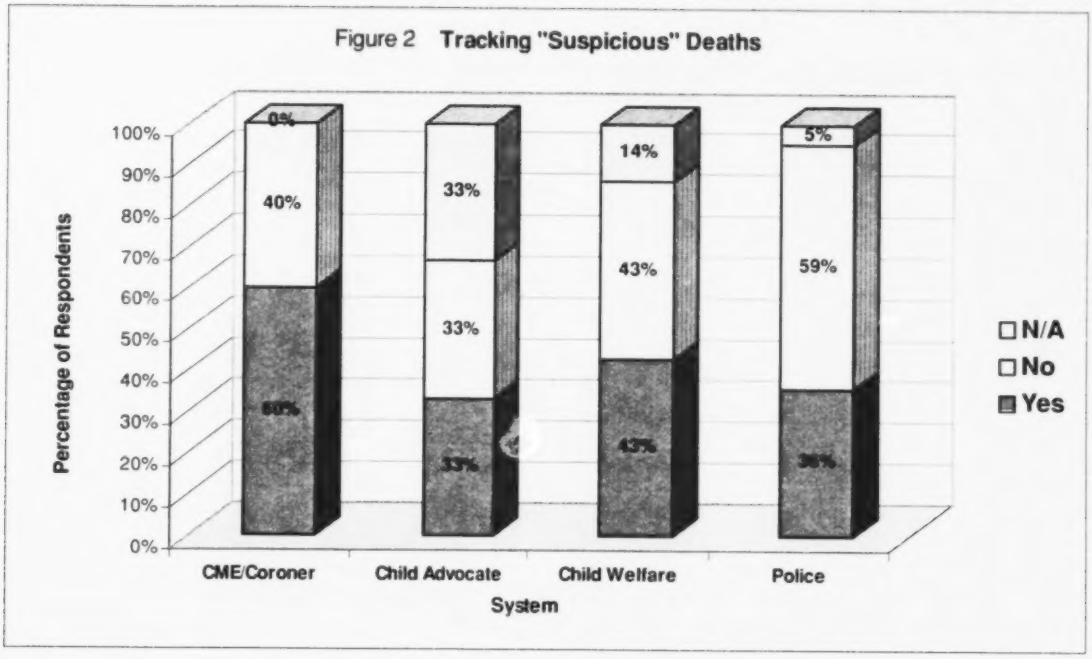
N = 37

respect to child fatalities varies across the country and across most systems with the exception of the Royal Canadian Mounted Police (RCMP). For example, informants were asked if they had 1996 statistics on child deaths in their jurisdictions. As shown in Figure 1, the Chief Medical Examiners' or Coroners' offices most consistently indicated they had statistics on child deaths. Approximately 75 percent of police and child advocate informants who responded to the survey responded that this information was "unknown", meaning that they do not collect data specific to child deaths but rely on the CME/Coroners' offices or other sources to provide them with this information. (The survey question could also have been answered with "yes" or "no" with respect to the collection of death statistics.) The limited responses obtained from child welfare agencies suggest that this information is not consistently collected or made available. The large percentage of "unknown" among police represents two factors; the jurisdictional limits of municipal police forces' statistics and the limitations of statistical data collected with respect to child deaths. A common response was that data was tabulated according to charges laid rather than by age of victim.

How Systems Collect Data on Suspicious Deaths

There is a great deal of disparity across the country in terms of the way the various systems classify and retrieve information regarding 'suspicious' deaths. In fact, as shown in Figure 2, many informants reported that they do not have a process for tracking these child deaths. A common response from Police was that all child deaths are treated as 'suspicious' until such time as the investigation proves otherwise. The responses to the concept of 'suspicious' child deaths highlighted the ambiguity that exists surrounding this term. Many informants used other terminology to characterize these deaths, such as 'questionable', 'non-accidental', 'sudden' or that the manner of death was 'undetermined'.

The Office of the Chief Coroner in BC explained that 'suspicious' is not a term that is used frequently in the Coroner's Service because all deaths are initially treated as suspicious until a thorough investigation proves otherwise. Few of the systems surveyed had a process for retrieving information on "suspicious" child deaths for later analysis. As



mentioned below in the discussion of data collection systems, some provinces are in the process of developing systems or have just implemented processes for retrieving information on this type of death. For example, the Chief Coroner's office in Ontario can retrieve information on all cases of child death that are 'undetermined'. The new system that is being developed will contain sub-categories for 'undetermined' to distinguish between possible child abuse and neglect deaths vs. other manners of death. The Chief Coroner's office in British Columbia gives each death a preliminary code, which allows for later analysis of possible or probable homicides.

How Systems Collect Data on CAN Child Deaths

Given the identified difficulties accessing information specific to the general category of child deaths, information specific to CAN deaths was reportedly even more difficult to access. Just over 50% of informants indicated that child deaths that are due to abuse and neglect are classified as such. (See Figure 3). This response highlights the definitional ambiguity that surrounds the terms 'abuse' and 'neglect'. As the U.S National Committee for Prevention of Child Abuse stressed in their 1987 report on child abuse and neglect deaths "until we break down the semantic barriers between professions and develop an accurate definition of child abuse and neglect fatality that is distinct from other types of fatalities, we can neither determine why it occurs nor assign a label to it and thus count it accurately" (Mitchell, 1987:3)

As shown in Figure 4 below, with the exception of Child Advocates, the majority of informants indicated that they have some form of centralized data collection system. Furthermore, 91% of CME/Coroners, 75% of Child Advocates, and 87% of Police indicated that their systems are computerized. The responses obtained from Child Welfare reflect a mixed picture, with 57% indicating they did not have a computerized system, 29% indicating they did have a computerized database, and

14% indicating that they were in the process of developing a new computerized system. Most informants in all systems across Canada acknowledged that there were significant limitations to their current data systems. Child Advocates were the most dissatisfied with their present data systems. In contrast, 87 percent of Police reported some level of satisfaction with their existing system. (See Figure 5)

Limitations of Data Systems

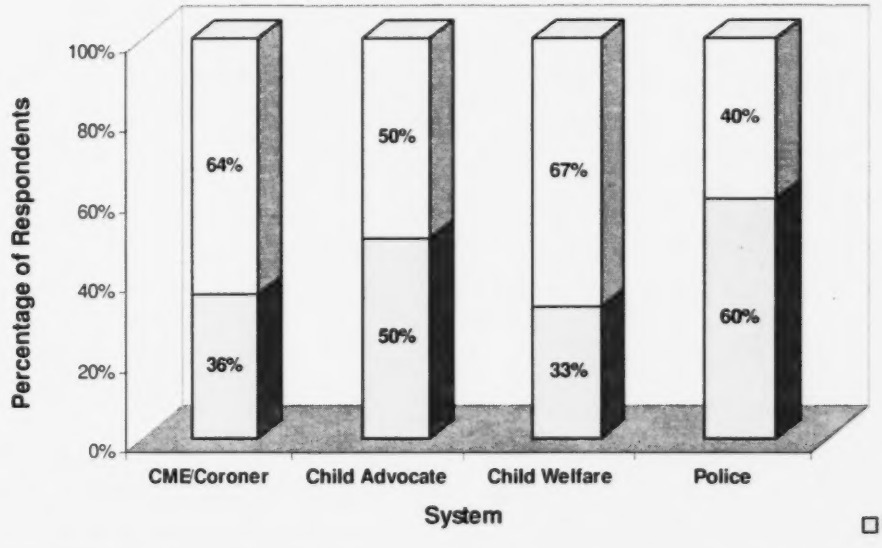
Several significant limitations to data systems were identified. These can be categorized as follows:

Compliance Problems The most commonly identified problem was that data was not collected consistently. Compliance was problematic in terms of collecting, reporting or entering pertinent data on child deaths into the database.

Database Design Problems Databases are organized in such a way that a number of informants in law enforcement and child welfare are not able to retrieve information specific to child deaths. A number of law enforcement informants were clear that they could not respond to queries about child deaths unless they were related to particular charges such as homicide, manslaughter, failure to provide the necessaries of life, etc. or to particular perpetrators or victims. Retrieving demographic information on cases in which no charges were laid, for example SIDS or injury deaths, was not possible as the databases were not designed for this purpose.

The databases of child welfare systems were usually set up as information or case management systems to assist in the ongoing work with families receiving service. Searching on particular types of deaths, e.g. Shaken Baby Syndrome deaths, was beyond the capacity of most of these systems. Many of the computerized systems stored data but were not designed so that staff (other than

Figure 3 **Ability to Categorize Deaths as Abuse or Neglect**



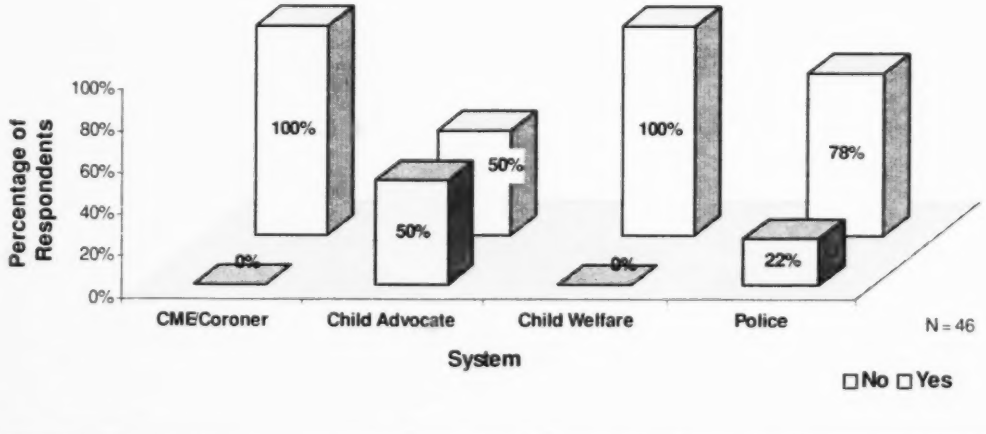
technical specialists) could "query" the database to produce reports and analysis. Not surprisingly, Coroners and Chief Medical Examiners experienced few of these barriers as their systems were designed to track and analyze information related to deaths, including child deaths. The British Columbia Children's Commission is currently "building" a database that will contain information on all the child deaths reported to the Commission. As this encompasses a wider scope than even the Chief Coroner's database, it has the potential to be a valuable data source in the future.

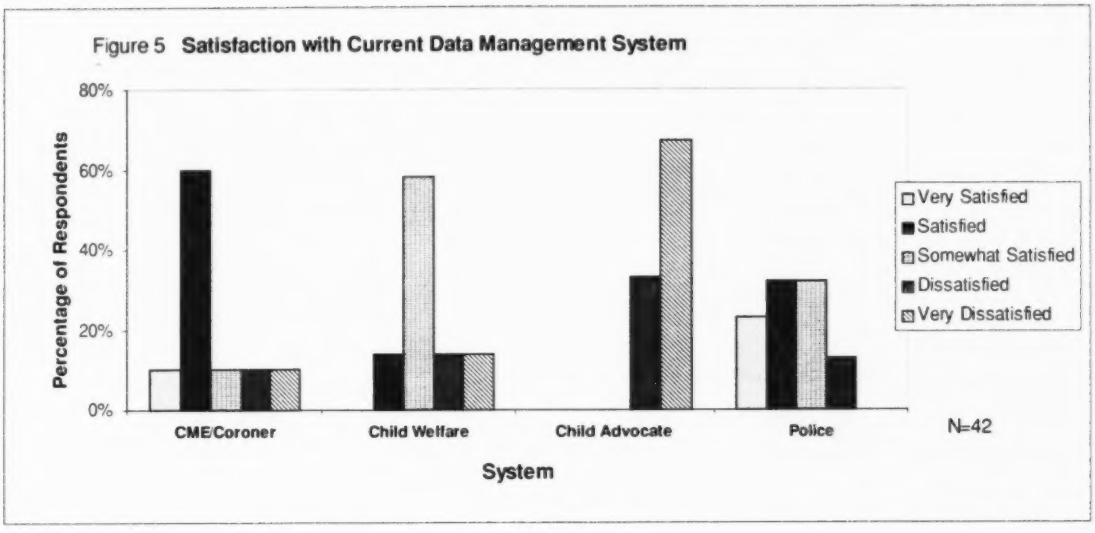
Retrieval and Exchange of Information Problems Child welfare informants indicated that there is inconsistent information-sharing internally between offices and also between child welfare agencies. Some of the Police indicated that information on child deaths in the CME/ Coroners database is not always readily accessible to police personnel. A number of key informants indicated that information on child deaths could be found in their paper files but their data management systems did not have the capacity to extract this information or the data was not entered into the systems in such a way that it could be extracted.

The majority of informants reported that information exchange with other systems is most often verbal or written. Some informants indicated that they are in the process of establishing systems designed to retrieve and exchange information electronically. For example, the B.C. Children's Commission is moving toward establishing electronic links with the Ministry for Children and Families, Vital Statistics, and the Coroner.

Several provinces have recently implemented, or are in the process of implementing, new data management systems. For example, the Chief Coroners in Ontario and Northwest Territories, the Chief Medical Examiner in Manitoba and all police forces in Ontario have new systems being developed. Informants expressed optimism that these new systems will be better equipped to address some of the barriers to data collection and management outlined above. Generally, informants with the most sophisticated data management systems reported the highest levels of satisfaction.

Figure 4 **Centralized Data Collection**





Part 2 Data Collection

This component of the survey was designed to generate data regarding the information that is routinely gathered in child death cases. A review of the data collected in 9 provinces and 2 territories revealed a wide variety of data collection strategies operating across the country. Specifically, the results of the survey indicated varying amounts of information were collected in the following areas:

Deceased Information - including child's identifying data (e.g. age, sex, and ethnic origin) and child's medical history. Generally, the basic demographic data on the deceased child was consistently recorded. However, more specific information such as the child's ethnic origin, or any disabilities or medical conditions of the child was less likely to be documented. For example, close to 40% of informants did not collect information on whether or not the child had any disabilities. Similarly, approximately 15% of informants indicated that they did not collect information regarding previous incidents of abuse and neglect of the deceased child.

Caregiver Information - including mental health problems, alcohol/substance abuse, criminal history, child welfare involvement. This data is extremely varied. For example, while over 90 percent of informants indicated that they recorded information on the caregiver with whom the child resided at time of death, many informants did not collect information pertaining to history of domestic violence, child abuse or neglect victimization, past child welfare or criminal involvement. Many of these variables would provide useful information for risk assessment and prevention efforts. The extent of this information also varies according to the focus or priority of the agency/ organization. For example, the Police indicated that they collect extensive information on the caregiver only if the caregiver is a crime suspect.

Perpetrator Information - including mental health problems, alcohol/ substance abuse, criminal history and child welfare involvement. Over 20% of informants indicated that they did not collect any information on the perpetrator. Those that did collect information on the perpetrator did so in an inconsistent manner. Overall, the police have the most comprehensive information on the perpetrator.

Family Information - including family income, employment, sibling information, any abuse of siblings, child welfare involvement with siblings. Approximately 27% of informants indicated that information pertaining to domestic violence, such as previous incidents of abuse or neglect of siblings or previous incidents of spousal abuse was not collected. The majority of informants (87%) indicated that they do record information on previous family involvement with child welfare agencies.

Information on Circumstances of Death - including the manner, cause, place, circumstances, and classification of the child's death; details of maltreatment deaths, and death risk factors. Key informants provided a wide range of general categories used to classify the cause of child deaths. The classification system most often used is comprised of five categories: accident, homicide, suicide, natural, or undetermined. The category 'undetermined' refers to a "death which, because of insufficient evidence or inability to otherwise determine, cannot reasonably be classified as natural, accidental, suicide or homicide" (Addendum to survey response, Office of the Chief Coroner of BC, 1998).

Agency Information - including Child Welfare information, Law Enforcement information, Medical Examiner/ Coroners information and Child Advocate information. The results of the survey reflected the orientation of the different systems used to collect information on child deaths across the country. Several Child Advocates indicated that they were very interested in the results of this study but currently do not collect data on child deaths. The responses obtained from child welfare officials suggested a wide range of information is collected in different jurisdictions. This makes it difficult to examine national trends with respect to child deaths. It severely limits the ability of systems responsible for the care and welfare of children to communicate effectively with one another and share information about child deaths.

Child Death Investigations and Existing Review Bodies in Canada

Across the country, each province or territory has developed processes for investigating the deaths of children based upon provincial or territorial law and Canada's Criminal Code. Internal review processes have been a part of many investigations in attempts to ensure their services were effective and met the requirements of law and public policy. Recently, a move toward multi-disciplinary review teams or committees has arisen as coroners and medical examiners, child advocates, police and child welfare professionals look for ways to meet public demands for accountability and effectiveness in service.

With the exception of one province, information was obtained from each province or territory through survey or semi-structured interviews (or both). Differences in emphasis between descriptions of jurisdictions do not suggest that one area has a "better" process than another. It reflects which systems responded to requests for interviews as well as the detail that was provided during those interviews. A further clarification concerning the use of "inquiry" is necessary as it refers in different Coroner/CME systems to different processes according to the context in which is it used. An inquiry can be the first level of investigation into a child's death. A "Judgement of Inquiry" is an inquest that is conducted by the review of written submissions to the presiding Coroner or provincial court judge. An inquiry also refers to a "public inquiry", usually a wide reaching process, beyond the scope of an inquest, for examining the circumstances surrounding a death.

Survey Findings:

Criteria for Child Welfare Death Reviews

Considerable diversity was found across systems and across provinces in the methods used to review child deaths. However, closer examination revealed differences with respect to which child deaths are selected for review, who participates in reviews and what the objectives are for the process. These differences necessarily affect the scope of reviews but the common factors include an assessment of the quality of services provided measured against the applicable legislation and standards and the resulting recommendations directed toward correcting any identified shortcomings. The survey findings indicate that there is no universal standard for selecting cases for review. Responses received from provincial and territorial child welfare systems identified the following divergent criteria for selecting cases for review:

Northwest Territories - The deaths of all children between the ages of 8 days and 16 years (as part of a review by a territorial committee)

Nova Scotia - Children (under the age of 16 years) who died as a result of child abuse while receiving child protection services.

New Brunswick - A deceased child (under the age of 16 years; under 19 years if disabled) who was known to Child Protection within one year prior to the death or was in the legal care of the Department.

Manitoba - Where the parents, siblings, or the deceased child (aged 17 years or younger) received services from a child welfare agency within two years prior to the death of the child.

Ontario - All deaths of children under the age of 18 years receiving service from a Children's Aid Society during the previous year, including natural deaths.

Criteria for Chief Coroner's/Chief Medical Examiner's Death Reviews

All Chief Coroners and Chief Medical Examiners have the ability to call for child death reviews through inquiries or inquests as circumstances demand. The selection criteria for routine case reviews by Chief Medical Examiners/Coroners in Canada included:

British Columbia - All child deaths (18 years and under) are scrutinized with investigations undertaken after reviews at varying levels in the coroner's system.

Yukon Territory - Child deaths (under 18 years) in which there are any prevention issues are reviewed (inquest or inquiry). In addition, child deaths are reviewed if there are questions an inquest can answer (such as manner of death), if there is a need for focusing public attention of this type of death or if there is a public outcry for an inquest.

Alberta - A review (inquest or inquiry) occurs if the next of kin requests an inquiry or when the Cause of Death is violent or undetermined. All deaths of children (under 18 years) who are wards of the Government are reviewed.

Northwest Territories - All child deaths under the age of 16 years are reviewed by the Coroner's office.

Saskatchewan - If the child death (under the age of 18 years) is unexplained or unnatural, the police investigate on behalf of the local Coroner or the Chief Coroner.

Manitoba - All 'non-natural' deaths and 'natural' deaths of children (under 18 years) are reportable and are reviewed by a medical examiner's investigator or a medical examiner. Intra- and post -operative surgical deaths are reviewed by a medical examiner.

Ontario - All child deaths (under 18 years if under an agreement for service or under 16 years otherwise) where a child is receiving child protection service at the time of death and all deaths of children under the age of two years, in addition to complex child deaths where police, coroner's office or other agencies or family have concerns are reviewed by the Coroner's office.

Quebec - All child deaths (under 18 years) from violent or unknown causes, including accidents, suicides, homicides and deaths of undetermined cause, are reviewed by the Coroner.

New Brunswick - All cases of child death (under 19 years) are reviewed by staff of the Chief Coroner's office with the inquest process in mind.

Newfoundland - All deaths of children are reviewed; child protection legislation defines "child" as under 16 years but wardship extends to age 19 subsequent to court order.

Informants from British Columbia, Ontario, Manitoba, and Northwest Territories indicated that some systematic analysis of child deaths has been conducted to better understand issues of concern. British Columbia's review was initially in response to one death[3] while Ontario's resulted from the observations of the Chief Coroner's pediatric death review committee and the concerns of the Ontario Association of Children's Aid Societies. Manitoba's review occurred in response to a clustering of deaths of children receiving child welfare services.

The findings from the surveys indicate that multi-disciplinary teams are not always utilized for child death reviews. Over 70 percent of respondents from provincial or territorial child welfare systems and CME/Coroners utilize multi-disciplinary teams when reviewing selected cases of child deaths. All the Child

Advocates with a mandate to review child deaths employ a multi-disciplinary approach. As shown in Figure 6, police were least likely to use a multi-disciplinary approach in case reviews.

An Overview of Provincial and Territorial Responses to Child Deaths

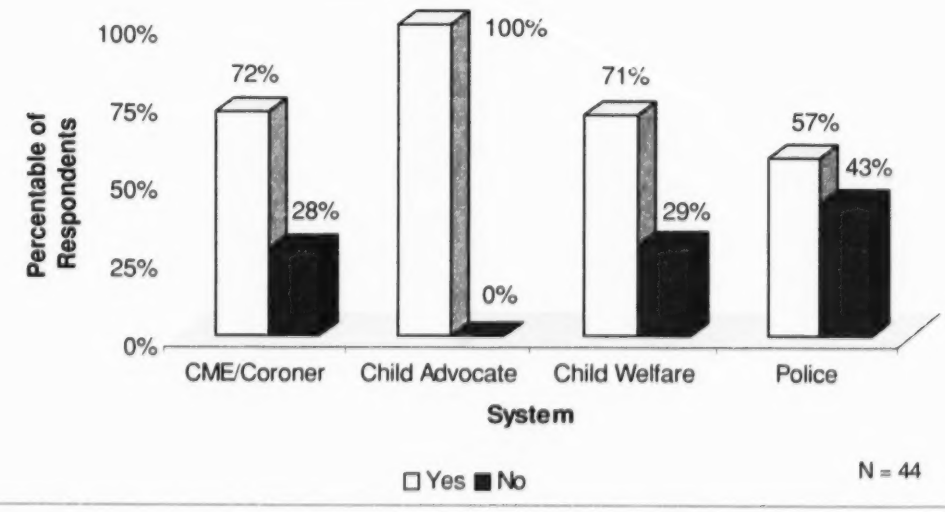
British Columbia

The Government of British Columbia, in responding to Justice Gove's report on the death of a young child, Matthew Vaudreuil, at the hands of his mother, implemented a system of checks and balances to protect children and to ensure that the deaths of children received close scrutiny from a multi-system perspective. The creation of the Ministry of Children and Families was announced in September of 1996, bringing together all child-related services (except educational services) under one ministry. The work of the Children's Commission is to assess government services for children and youth under 19 in British Columbia, and to advise government on improving these services. This may include the review of child deaths where the Commission reviews the circumstances leading to the death of any child or youth in British Columbia. The purpose of the review is to make recommendations for changes that could help children and youth in similar situations. The Children's Commission reviews the cases of children and youth in government care who sustain critical injuries, and recommends changes aimed at better protecting these young people. (http://www.childservices.gov.bc.ca/work/investprocess.html)

Deaths of Children

British Columbia has a coroner system with a Chief Coroner, regional coroners and local coroners. Local coroners can be either physicians or laypersons. Approximately 300 child deaths are investigated every year through the Chief Coroner's Office. The Office has complete protocols for infant death investigations including toxicological analysis,

Figure 6 **Use of Multi-disciplinary Teams**



autopsy and Sudden Infant Death protocols. Sudden or unexpected deaths of children are investigated; as are all Sudden Infant Death Syndrome deaths, all homicides and suicides in addition to some natural deaths that have not been issued death certificates by a physician. A unique investigative feature is the creation of psychological profiles of each child who commits suicide. Local police or RCMP assist the coroners in death investigations under the provincial Coroner's Act. In addition, a Coroner's Constable functions as a liaison between the coroner's office and the police with respect to the flow of information and paperwork. The Chief Coroner notifies Vital Statistics and the Children's Commission of all reported child deaths. The Chief Coroner is a member of the Children's Commission's consultation committee and is involved in its death review process.

British Columbia coroners, are assisted in their work by members of municipal police forces or the RCMP under the provisions of The Coroner's Act. Any notice of a sudden death of a child, (including SIDS) or any child found upon investigation to have received services from the Ministry of Children and Families, is reported to the Coroner. Collaboration between police and child welfare officials is not mandatory, but a joint investigation may occur if the police investigator and child welfare worker are in agreement to do so. Only one police force expressed concern about already scarce police resources being stretched to breaking by any additional demands for service from multi-disciplinary child death review teams.

Investigation of Deaths of Children Known to the Ministry of Children and Families

The Children's Commission receives notification under The Children's Commission Act of the deaths of all children from three sources; the province's Chief Coroner, the Ministry of Children and Families and the Department of Vital Statistics. Reporting criteria include all child deaths, including accidents, medical misadventure and violent deaths in addition to any child who dies while in the care of the government. Some expected deaths are reviewed with respect to service delivery issues.

Investigations are undertaken on 55 to 60 percent of deaths reported to the Commission, both expected and unexpected, and include an examination of the life and death of the child. The purpose of the investigation is to draw conclusions about the services provided to the child (and family) by particular government departments including the Ministry of Children and Families, to identify systemic issues and to offer recommendations for improving service at both a local and provincial level.

Child Death Reviews

The Children's Commission utilizes a multi-disciplinary consultative committee for advice concerning the reports that are released. The Commission's consultative committee includes the Chief Coroner and representatives from British Columbia First Nations, the legal profession, pediatrics, and social work as well as consultants in aspects of child welfare practice. The Children's Commission Act places the responsibility for reviewing child deaths on the Commissioner. In turn, the Commissioner brings before the consultative committee the results of investigations in draft report form. Members usually comment within their areas of expertise but are able to offer comment on any aspect of the case or investigation.

The Commission's death investigations utilize information from the police, the child welfare system, hospitals, medical records, educational records, youth justice records and mental health records in addition to acquiring any additional information necessary to the

investigation. The Children's Commissioner and the Deputy Commissioner present a draft to the Commission's consultative committee which meets five times a year and reviews 20 to 40 cases at each meeting. At the meetings, consultative committee members can pose questions about the investigation and request additional details. After the draft has been approved, it is sent to any agency affected by the recommendations included in the report. A 30 day period allows agencies to respond. The final report includes the agencies' responses to the recommendations of the Commission. In beginning its work, the Commission was presented with a list of 190 deaths to investigate retrospectively. The Commission posts on its Website at *www.childservices.gov.bc.ca* the Annual and Special Investigation reports detailing its work. All death reviews are released, in non-identifying format, at periodic intervals (usually in groups of several reports at a time).

With respect to the Ministry for Children and Families, the child fatality review policy requires field staff to report within 24 hours any fatality involving a child receiving services or in the care of the Ministry. This includes any child who has received services within the twelve months prior to his or her death. The Ministry immediately notifies the Children's Commission according to written protocols with that office and the Coroner's office concerning the reporting and sharing of information about the deaths of children known to the Ministry. The Ministry undertakes its own review of each fatality through the office of the Director of Child Protection. Ministry case practises are examined to determine if services were provided in accordance with legislation, policy and practice standards. Recommendations may be made concerning changes in policy, training or practice. The Director's office tracks the implementation of such recommendations. A copy of each review is provided to the Children's Commission.

The province's Child Advocate has advised that the Office of the Child, Youth and Family Advocate has no mandated role with respect to child deaths.

ALBERTA

Deaths of Children

Alberta's Chief Medical Examiner is notified of any child death that is unexplained including deaths from violence or deaths of government wards. Sudden Infant Death Syndrome deaths are treated as "unexplained" until an investigation determines otherwise. Alberta's Chief Medical Examiner uses the police as investigators in areas outside large urban centres. Medical Examiners' Investigators work in large urban centres to assist the province's Medical Examiners who are physicians.

The investigations of deaths of children under the age of four years routinely include a full body x-ray and the collection of samples for toxicological analysis. All pediatric autopsies are performed by forensic pathologists, and are routinely performed on all infants or children wherein the death is unexplained (including SIDS) or is unwitnessed or undocumented. In investigating children's deaths, the CME will provide to the Department of Family and Social Services, upon request, reports on the child's death.

Child welfare files are not routinely reviewed as part of the CME's investigation. Public fatality inquiries are held in all deaths of children when the child was a ward of the government under the Department of Family and Social Services. The Fatality Review Board, which is composed of a physician, a lawyer and a lay person with the Chief Medical Examiner as a fourth ex-officio member, reviews the files of all unnatural deaths of children and can recommend to the Minister

of Justice that a public fatality inquiry be held into any of these deaths. Fatality inquiries are held before a provincial court judge who is responsible for establishing the identity of the deceased, the medical cause of death and the manner of death. Recommendations may be made in an effort to prevent similar deaths in the future. As the inquiries are case specific, systemic issues are less easily addressed.

Police forces in Alberta assist the CME in the investigation of deaths in which no criminal charges are expected. As in other jurisdictions, once a likelihood for a Criminal Code charge has been identified, the police must undertake their own investigation, following their own protocols. The CME remains involved and the Office of the CME continues to investigate to determine the manner and cause of death. The Edmonton Police Service reports that it notifies the Director of Child Welfare of any confirmed or suspected child maltreatment deaths. The provincial department of Family and Social Services is involved in these investigations unless there are concerns about the actions of Family and Social Services. The force has a Child Abuse Unit that will begin the investigation of an abused child, yielding the primary role to the Homicide unit should the child die. In communities without a municipal police force, the RCMP has a contract for policing. The RCMP polices the northern two-thirds of the province. Its members assist the CME with investigations of child deaths that are not clearly accidental; for example, a bathtub drowning of a young child would be investigated, as would a malnutrition death of an infant with multiple caregivers. Members work closely with Family and Social Services on shared cases.

Investigation of Deaths of Children Known to Provincial Child Welfare Services

Alberta is moving to a system of regional authorities who will be responsible for delivering child welfare services as agents of the Alberta Ministry of Family and Social Services. Line supervisors and staff have advised the researchers that there is an internal, departmental review process after the death of any child receiving services from the province's child welfare department.

A physician, a lawyer and a member of the general public are appointed to the province's Fatality Review Board by the Lieutenant Governor and the Chief Medical Examiner sits as an ex-officio Board member. The Board reviews all cases of accidental and undetermined deaths and any deaths that occur in a provincial institution or involve a ward of the Court.(http://www.gov.ab.ca/acn/199804/6128.html)

Child Death Reviews

The Office of the Chief Medical Examiner is contemplating the creation of a child death review team, taking into consideration that there needs to be a clearly defined role for such a team. In addition, the CME's office already has access to non-medical expertise on a case by case basis.

SASKATCHEWAN

Deaths of Children

The Chief Coroner of Saskatchewan is notified (usually by police, physicians, hospitals or, on occasion, by citizens) of the death of a child from any unexpected or unnatural cause. Notification to the Chief Coroner is optional if the child's death is expected, due to natural causes or if a physician completes the death certificate.

If the deceased was under the age of 21 years, the Coroner's Office notifies the Department of Social Services (DSS). The DSS determines if there has been child welfare involvement. In investigating the deaths of young children, the Chief Coroner orders full body x-rays for children less than three years old as part of the autopsy process. After reviewing the report of the local coroner and the pathologist, the Chief Coroner may direct that any anomalous or conflicting information be investigated further. Coroners (both lay coroners and physician coroners) in Saskatchewan are assisted by police, including municipal police forces and the RCMP, in any investigations of child deaths that fall under The Coroner's Act. Coroners are called to attend to child death calls received by the police.

Investigation of Deaths of Children Known to Provincial Child Welfare Services

The Office of the Children's Advocate advised that DSS has its own internal review policies and will produce a report after the death of a child receiving service. A copy of the DSS report is provided to the Chief Coroner. The Children's Advocate is advised of the death and is provided with a report on the Department's involvement. The Children's Advocate's review focuses on the quality of service provided and identifies any gaps or failures to follow legislation and standards.

Police are accustomed to conducting collaborative investigations with the DSS if the child had been receiving service or the cause of death appears to be related to maltreatment. While The Coroner's Act is sufficient for entering premises for a death investigation, any suggestion of a criminal investigation requires that a warrant be obtained for gathering evidence. The RCMP reported that it employs its own internal review system based on an independent, self-management system for reviewing its actions after investigating the death of a child. Files are self-audited according to established review procedures and are selected from different case categories in addition to being subject to review by division headquarters.

Child Death Reviews

At the time that the research for this report was being conducted, the Saskatchewan Children's Advocate issued the report on the first child death review conducted by that office. In issuing the report, the Children's Advocate initiated a process of "comprehensive and holistic" review of the life of a child who died of injuries sustained while in the care of the Department of Social Services. [4]

All deaths of children receiving services from the Department of Social Services are reported to the Children's Advocate. The Ombudsman and Children's Advocate Act confers the authority for the Advocate to initiate a review and the office has developed principles and statements of purpose for a child death review.[5] A multi-disciplinary committee was set up for the first review including investigators from the Advocate's office, a law enforcement consultant who was a member of a First Nation, a professor of paediatrics and the Chief Coroner as external consultants in addition to the Advocate's general counsel.

The Advocate's office is notified of the Chief Coroner's determination about the manner of a reportable death; whether it is unusual or suspicious. The Children's Advocate office then begins a multi-stage process of investigation and review of the results of its investigations. This may involve the formation of a multi-disciplinary team. When the multi-disciplinary team Chair is satisfied with the report, it goes to the Children's Advocate for review. The final draft is then distributed to any government departments or agencies named

in the recommendations and to the families of the child or children concerned. Once the families, the departments and agencies have responded within the 30-day period provided for such responses, the report may be released to the public. The Office of the Children's Advocate follows-up on the implementation of its recommendations.

The Children's Advocate chairs the Child Death Advisory Committee set up to address issues of policy and process related to the deaths of children. The Chief Coroner sits on this committee which is in the process of developing its Terms of Reference. Its purpose is to make recommendations to government on systemic and policy issues related to the deaths of children. The Office of the Chief Coroner is supportive of Saskatchewan's child death review processes as they promote better understanding of issues related to the deaths of children and improve the sharing of information between service providers. In addition, the committee is able to bring forward concerns about parent education for young parents including cautions about co-sleeping, over-wrapping of infants and abuse of over-the-counter medications.

MANITOBA

Deaths of Children

In Manitoba, the Chief Medical Examiner is notified of the death of a child by the police, hospitals, emergency medical services, child welfare agencies or any citizen wishing to have a death reviewed. In turn, the Director of Child Welfare responds to the CME's query about whether the child, the siblings, the parents or the guardians received services during two years prior to the child's death. All non-natural, sudden and unexpected deaths of children under the age of 18 years are investigated beyond the level of a basic inquiry into the "W5"; the "who", "what", "where", "when" and "why" of the death. Recent changes to investigation protocols have ensured that intra-and post-operative child deaths will be reviewed by a Medical Examiner. In Winnipeg only, Medical Examiner's Investigators (usually registered nurses) assist Manitoba's medical examiners. Outside the city, medical examiners (physicians) are assisted by police.

Autopsies of Manitoba children are performed by pediatric pathologists and x-rays are reviewed by a radiologist. All children have toxicology tests done and swabs for sexual abuse are taken. In addition, metabolic studies are done on children under the age of two years. Autopsies are "full" autopsies as Manitoba's Fatality Inquiries Act directs that all three body cavities be examined. Toxicology studies can provide surprising results; for example, a four month old infant was found to have been administered a small dose of diazepam. A sibling (born after the infant's death) was tested when the toxicology results were received and also showed a small amount of diazepam in the blood screen. A recent case involved a very young infant whose toxicology results revealed a large amount of a non-prescription medication.

The Winnipeg Police Service Child Abuse Unit is involved in the investigation of child deaths, although the Homicide unit takes the primary role in deaths believed to be due to homicide. An internal review process exists for homicide cases and the force has the services of a "Q and A" analyst for statement analysis in addition to the usual forensic specialists. The force participates in the province's multi-disciplinary review process as it promotes discussion of cases and ensures that no relevant history is missed during an investigation. Concerns about confidentiality and communication between the police and

Child and Family Services have been addressed in recently proclaimed amendments to the province's Child and Family Services Act. The RCMP assists medical examiners in communities where there is neither a municipal police force nor Medical Examiner's Investigators. As occurs elsewhere in Canada, the investigation changes focus if the RCMP believes that charges under the Criminal Code are possible. The CME's investigation parallels the RCMP criminal investigation as the Medical Examiner determines the manner and cause of death.

Investigation of Deaths of Children Known to Provincial Child Welfare Services

There is a provision in Manitoba's Fatality Inquiries Act for a confidential review of all services provided to the deceased child and the family by any of Manitoba's child welfare agencies. The review is based upon the provincial Program Standards for child welfare service and The Child and Family Services Act. Material from agency files is used, supplemented when necessary with interviews with staff. The resulting report and its recommendations are provided by the CME to the Minister of Family Services. Legislative change occurred in April of 1999 to allow the CME to release non-identifying information about the recommendations contained in these reports. The CME's reports are forwarded by the Minister of Family Services to Child and Family Support Branch in the Department of Family Services for distribution. The Support Branch provides the agencies concerned with copies of reports and time lines for responding to and/or implementing the recommendations. Follow-up of the CME's recommendations is undertaken through the Child and Family Support Branch in the Department of Family Services. The Minister of Family Services may also use independent consultants to conduct an audit of service (in addition to the mandated review by the Chief Medical Examiner) or may call upon senior staff in the Department of Family Services' Child and Family Support Branch to provide a report.

Child Death Reviews

Manitoba has Canada's oldest multi-disciplinary child death review committee. It was formed in 1992 through the Provincial Advisory Committee on Child Abuse (PACCA) and includes a representative from the Winnipeg Police Service Child Abuse Unit, the RCMP, the Child Protection Centre, the Department of Family Services as well as a pediatric pathologist, a pediatrician representing the College of Physicians and Surgeons, a Crown Attorney and the Child and Family Services Adviser from the Assembly of Manitoba Chiefs. The committee is chaired by the CME and is an ad hoc committee of the CME's office. The committee reviews all non-natural deaths of children and any death of a child involved with a child welfare agency. While the committee was originally formed to advise the CME on calling inquests, it has evolved into a multi-disciplinary review committee that thoroughly reviews all aspects of a child death. Committee members bring information about their involvement in the cases and decisions are made to investigate cases further, to call inquests or to attempt to prevent similar deaths by communicating the Committee's concerns to individuals, agencies or government. Recommendations are not legally binding.

Support for multi-disciplinary child death reviews is high in Manitoba. All informants were in favour of the process, believing that it improved communication, provided accountability and ensured the identification of abuse or neglect deaths. It has been suggested that the Committee, known as the Children's Inquest Review Committee (CIRC)

needs to develop Terms of Reference and consider additional members from the mental health and public health systems.

Manitoba's Child Advocate has no mandated role in child deaths unless a family member or the media requests the Advocate's involvement. The Advocate receives no formal notification of the death of a child but can request and review reports from the CME and the Director of Child Welfare concerning the deaths of children served by the office. At the completion of the review, the Advocate may make recommendations to the Minister of Family Services. Recent recommendations have urged that the Minister of Family Services routinely provide the CME's reports to the Advocate and make the CME's recommendations public.

ONTARIO

Deaths of Children

The Chief Coroner is notified of all deaths of children due to accidents, suicide, and homicide as well as all sudden and unexpected deaths of children. The Children's Aid Societies report all deaths of children receiving child welfare services during the previous year, including natural deaths. The Chief Coroner notifies police of all child deaths as there have been occasions of SIDS deaths not being reported to them.

A system of eight regional coroners oversees the work of 350 local coroners, all of whom are physicians. The coroners are assisted in their investigations by municipal police forces or by the Ontario Provincial Police (OPP). In investigating the deaths of children, the coroner begins every investigation as if the death were a potential homicide. If the provisional cause of death is SIDS, the investigation must be "clean" of other risk factors or the death will be classified as an "Undetermined" death. If the manner of the child's death is undetermined, resembles SIDS and the child is under the age of two years, it may be classified as a SUD or sudden unexpected death. Children under the age of two years are autopsied with full body x-rays and toxicological analysis. A forensic radiologist views the x-rays before the body is released, ideally before the autopsy. In the future, all deaths of children under the age of 5 years will be autopsied by four designated pathologists.

In certain circumstances, an autopsy may be waived; for example, if the child dies in hospital with adequate documentation of an illness or terminal condition or if the family's religious beliefs dictate burial within a limited time span. However, should charges be contemplated or another agency or entity involved, an autopsy is done. As in most of Canada, sexual abuse tests are done only if the circumstances suggest they are necessary. (Manitoba is the exception to this rule as swabs are routinely taken so that tests may be ordered at some future date if necessary.)

Investigation of Deaths of Children Known to Provincial Child Welfare Services

Six high profile child deaths in Ontario resulted in major changes to the province's system of investigating child deaths and the deaths of children in the care of Children's Aid Societies (CAS). The Office of the Chief Coroner initiated the Ontario Child Mortality Task Force in April of 1996 in conjunction with the Ontario Association of Children's Aid Societies (OACAS) and with the support of the Ministry of Community and Social Services (MCSS). The Task Force published its initial report in the OACAS journal and has issued a progress report on its recommendations.

The Ontario Association of Children's Aid Societies is a membership organization representing 52 of 55 Children's Aid Societies in Ontario. Ordinarily, the OACAS is not involved in collecting data regarding child deaths. However, given the lack of knowledge and accurate information about child deaths in Ontario, the OACAS, along with the Office of the Chief Coroner and the Ministry of Community and Social Services, collected information about children who had died during a two year period of 1994 and 1995. The data collected from the field formed the basis of the reports of the Child Mortality Task Force. In responding to the over 400 recommendations of the Ontario Child Mortality Task Force, the Ministry of Community and Social Services is implementing a major Child Welfare Reform Agenda that includes: a mandatory risk assessment model and integrated standards for all child protection cases and the introduction of a Bill proposing amendments to child protection legislation. Additional reforms will see the development of an interactive provincial data base in conjunction with the Ontario Association of Children's Aid Societies for all child protection cases to facilitate prior contact checks, a volume-sensitive, rational funding framework for child protection services and a foster care revitalization strategy. The province will also provide pre-work training and competency based testing for new child protection workers in addition to requiring ongoing training for workers.

If the coroner feels that abuse or neglect has been a contributing factor, the appropriate CAS is notified. Representatives of the Ministry of Community and Social Services (MCSS) and the Coroner's office meet monthly to ensure that no CAS deaths are missed by the Chief Coroner. Ongoing issues of concern involve access by the CAS to information and parties during a criminal investigation.

Joint investigation by police with child welfare agencies was, in all interviews of law enforcement respondents, described as a positive process. A major concern was the confidentiality restrictions placed on CAS's when the police request information. Investigative support to municipal and urban forces on child abuse issues varies with proximity to teaching hospitals and universities with programs that focus on child maltreatment. For example, the regional police force in Hamilton-Wentworth has access to a range of resources through McMaster University and the police were well informed on issues at the local and provincial level.

After a reportable child death, information on the case circumstances from the CAS involved is due at the Ministry of Community and Social Services (MCSS) local office in 24 hours. Notification to the Coroner is also required. A more detailed report titled a Serous Occurrence and Child Fatality Survey is due within five days at the MCSS and the Coroner's Office. In submitting the two reports, the CAS in question is essentially reviewing its compliance with the Ministry's standards of practice. If further internal review is deemed necessary, a report from the CAS is submitted to the MCSS area office within 60 days.

The local MCSS office reports to the main Ministry office using a "contentious issue" reporting format within 24 hours of the child's death. The Ministry receives the CAS's reports and reviews them to determine if further action is required. The Children's Services Branch of the Ministry records the death in its Child Death Log within a week and receives summary information on deaths each month. Should additional review be necessary, the area office will receive the required CAS review within 60 days. The area office will then complete its own review, Report on the Death of a Child, within 90 days of the internal review. The Coroner's Office receives a quarterly report from the

Ministry on the child deaths that fall within the ministry's reporting protocols. MCSS has the option of requesting an independent, third party review of standards and compliance. This review may produce recommendations for the Ministry concerning the CAS or other agencies and the Ministry may require compliance from the CAS. (Third party reviews of clients of child welfare services are automatic in British Columbia, Saskatchewan and Manitoba). The Ministry's primary focus with child deaths is to ensure that, in addition to efforts to prevent similar deaths, the quality of CAS operations is maintained, that there is compliance with legislation and standards and that interaction with other systems is taking place in accordance with existing protocols.

Child Death Reviews

In 1991, the Chief Coroner's Office formed a medical committee to examine child deaths. The committee developed a child death investigation protocol and became increasingly concerned about the numbers of deaths of children associated with child welfare services. It was involved in the inititation of the Ontario Child Mortality Task Force. This committee has changed to a multi-disciplinary review committee, the Paediatric Death Review Committee (PDRC) and includes pediatrician and a pediatric forensic pathologist. It is chaired by the Deputy Chief Coroner and has added experts in child protection including the Executive Director of the OACAS, police force members with expertise in child abuse and homicide, a child welfare expert and a Crown Attorney whose sub-speciality is child abuse and neglect death prosecutions. Cases are summarized in draft form by one member, discussed and a collective report issued. Eight to ten cases are reviewed monthly and "highly suspicious" cases may receive a preliminary review and return for review after the criminal investigation has been completed. A reply to the committee's recommendations is requested from agencies or government but staff resources severely limit the committee's ability to follow up on its recommendations.

One of the recommendations made by the Ontario Child Mortality Task Force was that a coordinated process should be developed regarding the reporting, review and analysis of child deaths. This coordinated effort should include the CAS, MCSS and the Coroner. OACAS is working with the Ministry and the Chief Coroner to develop standardization and consistency in reporting. It is hoped that over time a child death review process which has a more local capacity might be developed. While the OACAS has no internal database, the development of the provincial database will ensure the ongoing collection of relevant data regarding child deaths.

The municipal police force representatives interviewed were clear that the process for reviewing child deaths has improved at the provincial level since the inception of the multi-disciplinary review committee.

In commenting on review processes, the Ministry of Community and Social Services believes that having a child death review process at a local level could improve notification and ensure more immediate improvements to practice. The Ministry noted that there is ongoing reluctance among many systems to come to terms with the issue of child deaths. Creating clearer standards and improving workload models are ongoing issues in MCSS' responses to child deaths.

QUEBEC

Deaths of Children

The current Coroner system in Quebec was implemented in 1986 after 15 years of study of existing systems. The scope of the study was international and the changes proposed were sweeping, however the complete plan has not been implemented due to budget restraints. The Chief Coroner of Quebec directs a system that has two streams of coroners; investigators, the majority of whom are physicians while some are lawyers or notaries; and inquest coroners who, under the Act, must have legal training. The role and function of the two types of coroner are identical; to determine the medical causes and circumstances of death, make recommendations where appropriate and produce a public report. The means of doing this differ; the inquest coroner has the additional power to subpoena witnesses and conduct a more formal quasi-judicial-like procedure which must be carried out in public. This system ensures uniformity of training and lends both consistency and structure to the process of death investigations in Quebec. In particular, those coroners who preside over inquests are able to maintain the focus and neutrality of an interest due to their legal training but are also familiar with public health issues by virtue of their training and experience as coroners.

Deaths of children from violent or unknown causes are reportable by police, hospitals and other citizens to the coroner responsible for the district where the death occurred. This covers a range of deaths including accidents, suicides, homicides and deaths of undetermined cause. Due to some misunderstandings and missed reports, the Chief Coroner is contemplating issuing a directive to more clearly define reportable deaths in the province. Deaths due to sickness or natural causes will not be reportable unless the attending physician is unable to complete the death certificate as to the probable medical cause of death. The police in Quebec, including urban forces and the Surêté de Quebec, assist coroners in their investigations. Should a criminal investigation be necessary, the Coroner's investigation continues parallel to the police investigation. It is a fallacy that the Coroner has no mandated role in a criminal investigation. In fact, it is only the Coroner who is mandated to authorize removal of the body from the scene and to order an autopsy. The Chief Coroner is an almost entirely independent entity under the new Act as the provincial government and executive essentially retain no direct management powers except the power to recommend and nominate coroners and make certain regulations upon consultation with the Chief Coroner.

Child Death Reviews

In 1997, the Chief Coroner introduced two multi-disciplinary child death review teams. One is located in Quebec City and deals with all child deaths in the eastern part of the province including the eastern portion of northern Quebec. The other is in Montreal and reviews cases in the western part of the province. Both meet monthly and use Coroner's reports as the main source of information. Lists from Vital Statistics are used to ensure that all reportable cases are reviewed. Case selection criteria include all non-natural deaths of children up to the age of five years. The committees are considering screening accidental deaths to eliminate those where there is no suspicion of maltreatment. All SIDS deaths are reviewed. As an example of how the committee has helped in the correct classification of deaths, the Deputy Coroner reported that a SIDS death with a small amount of acetaminophen appearing in the toxicological screen had other characteristics

that made the committee uneasy. Further investigation was requested and eventually, one of the parents admitted to asphyxiating the baby.

The two committees are set up along similar models; both are chaired by pediatricians with expertise in child maltreatment, both practice at a major Children's Hospital; the St. Justin Children's Hospital in Montreal and the University Hospital in Quebec. The Deputy Coroner sits on the Quebec City committee and a full time coroner sits on the one in Montreal. Each committee has a member from the Surêté de Quebec, the provincial police force, and the one in Montreal has a member from the SPCUM, the urban police force in that city. Both committees have members from the child welfare service; the one in Montreal also has a representative from Batshaw, the English child welfare agency. The Montreal committee has a pathologist from the Medical-Legal Laboratory; the province's main forensic sciences centre and can provide consultation to Quebec City. In June of 1997, at a joint meeting, the committees recommended to the Chief Coroner and the Minister of Justice that the committees be made a permanent part of the coroner service in Quebec. This recommendation has been accepted by the government of Quebec.

The Coroner's office has also made other changes in recent years to improve the investigation of children's deaths. Since 1994, the majority of autopsies of children have been performed by pathologists at the St. Justin Children's Hospital in Montreal or at the University Hospital in Quebec City. This has enabled the Chief Coroner to institute an autopsy protocol and quality controls. If the cause of death appears to be due to violence, the child is autopsied in Montreal. In cases of clearly accidental death, the autopsy may be performed in a community hospital.

NOVA SCOTIA

Deaths of Children

In Nova Scotia, the Chief Medical Examiner investigates the death of a child under the Fatality Inquiries Act. Informants advised that this legislation is dated, is not specific enough about reportable deaths and is silent on deaths of children receiving services from the provincial child welfare department. Autopsies are performed in cases where there is a concern about the cause of death and where there is injury, particularly unwitnessed injury or violence. There is no protocol for child autopsies as the pathologist determines what is necessary and may conduct more intensive testing if there is any suspicion about the cause of death. The Chief Medical Examiner's office has no internal review process for child deaths but is involved in efforts to initiate multi-disciplinary child death reviews in Nova Scotia. In the interim, if there was a need for review beyond what could be supplied at an inquest, the CME has the authority to request that a public inquiry be held.

The RCMP in Nova Scotia has its own internal review process for child deaths. The CME is notified of any child deaths reported to the RCMP. The Fatality Inquiries Act provides for mandatory notification of the CME by police services of any child deaths but does not provide for any mandated contact with social services concerning child deaths. The RCMP enjoys a good working relationship with the CME that includes an open exchange of information. The RCMP felt that information sharing still could be improved to increase the effectiveness of child death investigations. The informant was less sure about multi-disciplinary child death reviews, believing that cases would have to be finished in court before they could be submitted. Concern was expressed that reviewing cases while a criminal investigation

was ongoing might lead to a perception of interference and problems with accountability.

Investigation of Deaths of Children Known to Provincial Child Welfare Services

The province's Department of Community Services conducts its own investigations of the deaths of children who die while receiving services, while in the care of the Province or from abuse. This investigation is a parallel investigation to those of the police and the Chief Medical Examiner. The Department uses police and medical examiner reports to determine if it will be necessary to report to the director of child welfare. If the death meets the criteria above and if the cause of death is suspicious (anything unnatural or SIDS), an investigation commences. Field investigators work with police under a shared protocol and submit a report including the police and medical examiner reports. If the Department judges the report's findings problematic, an internal review may occur. The director of child welfare, the provincial child protection coordinator, a regional administrator, a regional child welfare specialist and a pediatrician (when medical input is necessary) author a report to the Deputy Minister who has the option of calling for an independent review. The need for these investigations is judged on a case by case basis. The focus is on the actions of the child welfare agency concerned and includes an action plan and recommendations. The action plan is designed to correct what the internal review has determined to be problematic. The recommendations are not binding but the agency is held accountable if it does not meet the Department's guidelines for child protection services.

The province's child welfare legislation lacks mandatory reporting mechanisms for child deaths and is highly restrictive with respect to information sharing. Nova Scotia's Department of Community Services supports the concept of multi-disciplinary child death reviews and has researched the operation of committees across the country. An issue of concern in developing a team approach is the province's tradition of independent systems with their own reporting and review mechanisms.

The police participate in joint investigations with the Department of Community Services when a child known to the child protection service dies from a cause that is unnatural or SIDS. In investigating a child death, the police check with "social services" to determine if there is a file open, but acknowledged that, if the family appears to be doing well, a check may not be done. There is no mechanism for mandatory checks or reporting at the current time. The current protocol does not require police attend autopsies unless circumstances dictate. An official from the Department of Justice sits on the Preventable Child Death Review Committee (PCDRC) to represent law enforcement; police do not sit on the committee in its present format. In response to a question about joint reviews of child deaths, a police informant noted that a team approach is represented in efforts to work cooperatively with social services, the CME and any other police in the province.

Child Death Reviews

In 1998 the province instituted the Preventable Child Death Review Committee. The committee's focus is on issues of policy, the formation of child death review committees, data collection and standardized protocols for death investigations. Although the committee does not review cases, it receives reports of the deaths of children involved with the child welfare system. The committee includes the province's Chief Medical Officer,

Figure 7: Review Team and Process

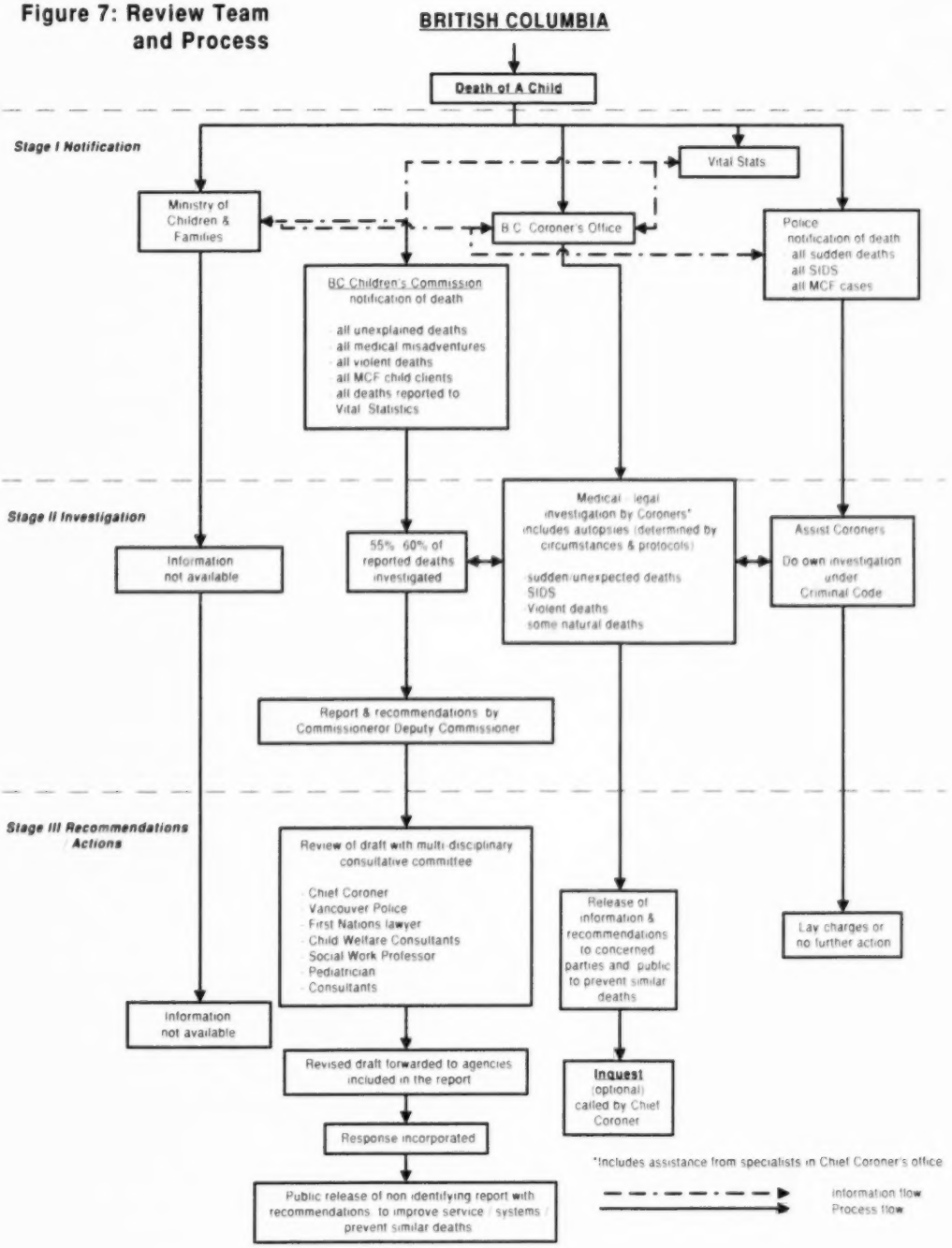

BRITISH COLUMBIA
Death of A Child
Stage I Notification
Vital Stats
Ministry of Children & Families
B.C. Coroner's Office
Police
notification of death
all sudden deaths
all SIDS
all MCF cases
BC Children's Commission
notification of death
all unexplained deaths
all medical misadventures
all violent deaths
all MCF child clients
all deaths reported to Vital Statistics
Stage II Investigation
Medical - legal investigation by Coroners*
includes autopsies (determined by circumstances & protocols)
sudden/unexpected deaths
SIDS
Violent deaths
some natural deaths
Assist Coroners
Do own investigation under Criminal Code
Information not available
55% 60% of reported deaths investigated
Report & recommendations by Commissioneror Deputy Commissioner
Stage III Recommendations / Actions
Review of draft with multi disciplinary consultative committee
Chief Coroner
Vancouver Police
First Nations lawyer
Child Welfare Consultants
Social Work Professor
Pediatrician
Consultants
Release of information & recommendations to concerned parties and public to prevent similar deaths
Lay charges or no further action
Information not available
Revised draft forwarded to agencies included in the report
Inquest (optional) called by Chief Coroner
Response incorporated
Public release of non identifying report with recommendations to improve service / systems / prevent similar deaths
*Includes assistance from specialists in Chief Coroner's office
Information flow
Process flow

Figure 8: Review Team and Process

MANITOBA

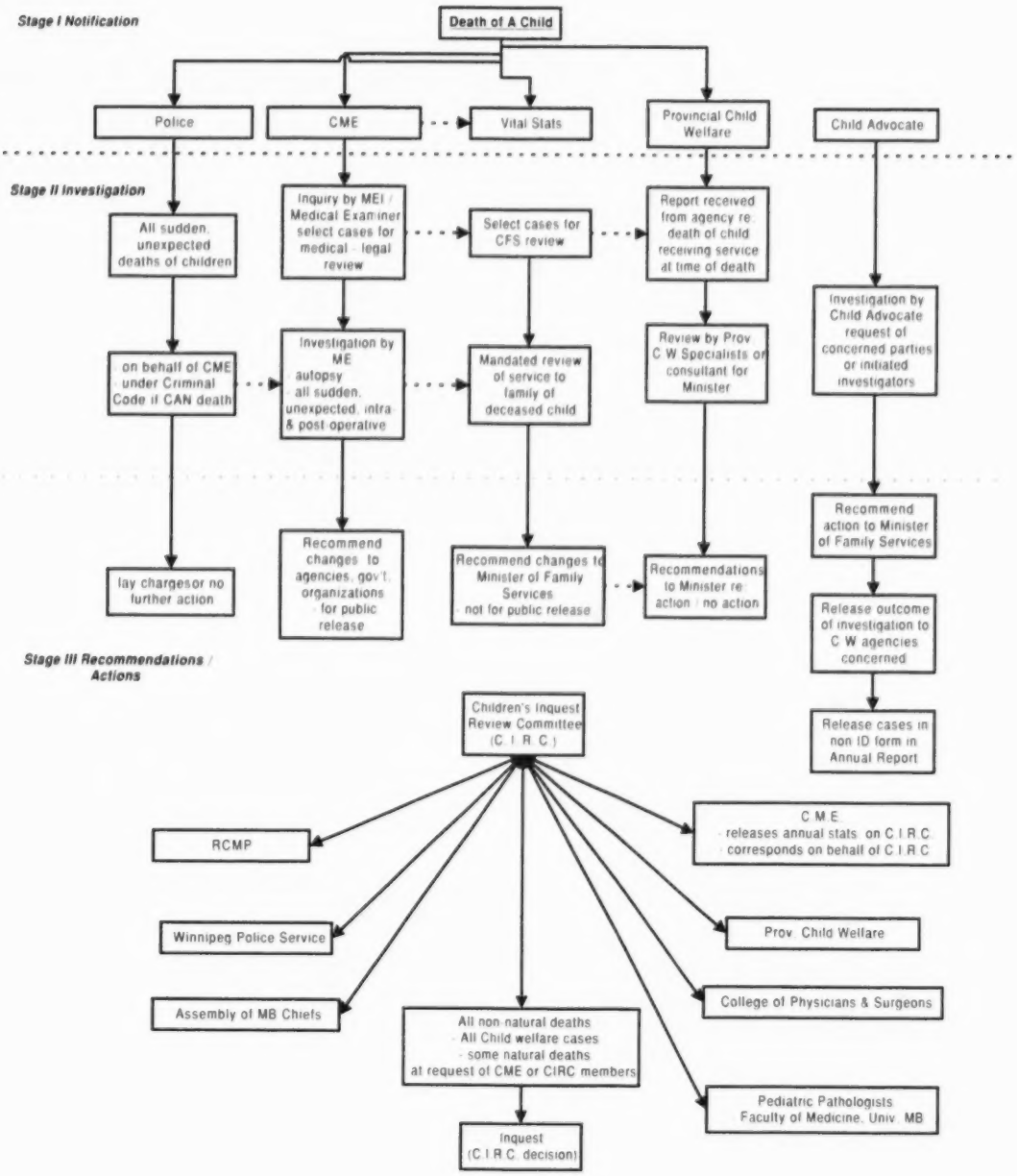

Stage I Notification
Death of A Child
Police
CME
Vital Stats
Provincial Child Welfare
Child Advocate
Stage II Investigation
All sudden, unexpected deaths of children
Inquiry by MEI / Medical Examiner select cases for medical - legal review
Select cases for CFS review
Report received from agency re: death of child receiving service at time of death
Investigation by Child Advocate request of concerned parties or initiated investigators
on behalf of CME under Criminal Code if CAN death
Investigation by ME autopsy all sudden, unexpected, intra- & post-operative
Mandated review of service to family of deceased child
Review by Prov. C.W. Specialists or consultant for Minister
Recommend action to Minister of Family Services
lay charges or no further action
Recommend changes to agencies, gov't. organizations - for public release
Recommend changes to Minister of Family Services not for public release
Recommendations to Minister re: action / no action
Release outcome of investigation to C.W. agencies concerned
Stage III Recommendations / Actions
Children's Inquest Review Committee (C.I.R.C.)
Release cases in non ID form in Annual Report
RCMP
C.M.E. - releases annual stats. on C.I.R.C. - corresponds on behalf of C.I.R.C.
Winnipeg Police Service
Prov. Child Welfare
Assembly of MB Chiefs
College of Physicians & Surgeons
All non-natural deaths - All Child welfare cases - some natural deaths at request of CME or CIRC members
Pediatric Pathologists Faculty of Medicine, Univ. MB
Inquest (C.I.R.C. decision)

Figure 9: Review Team and Process

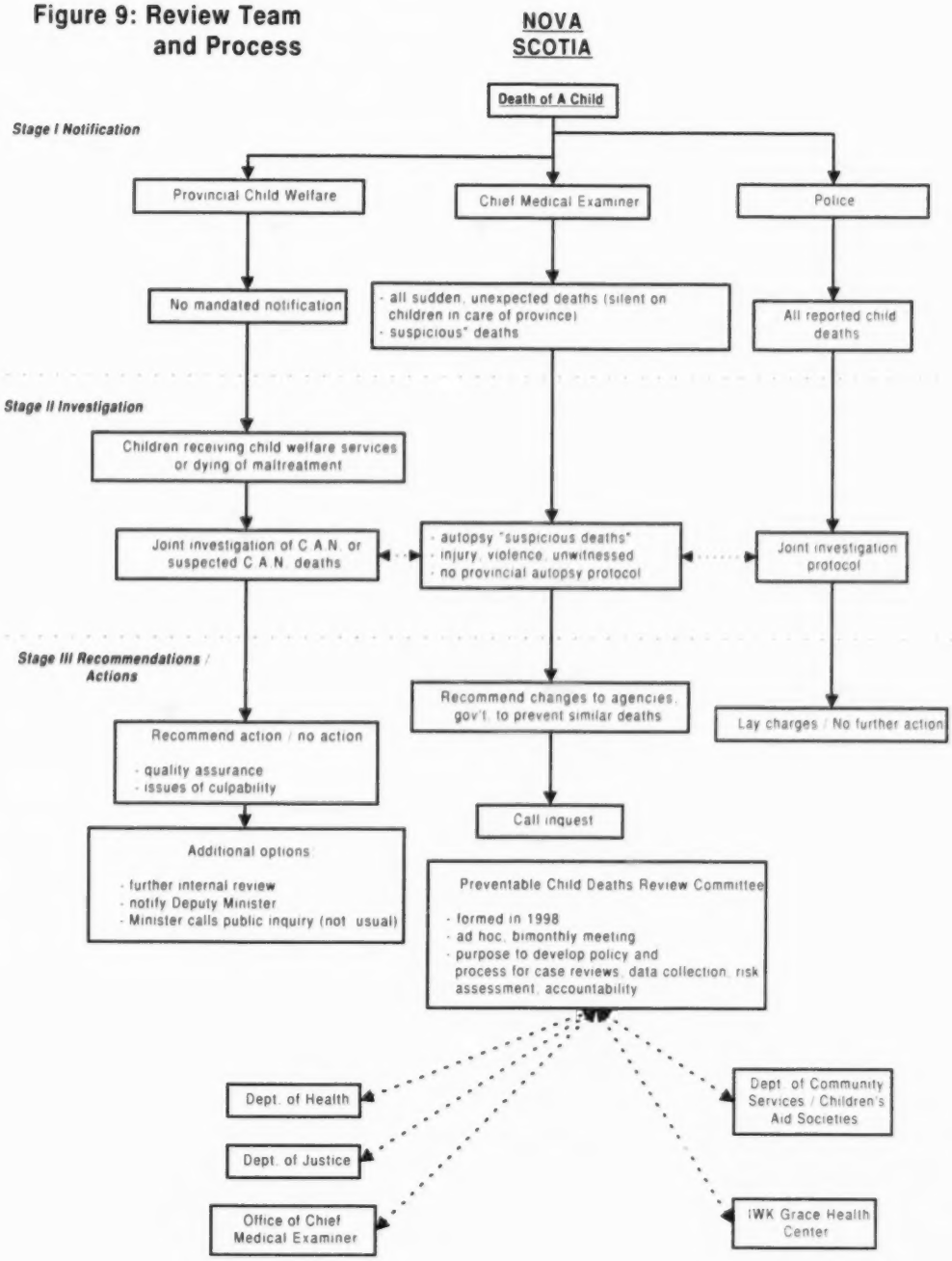
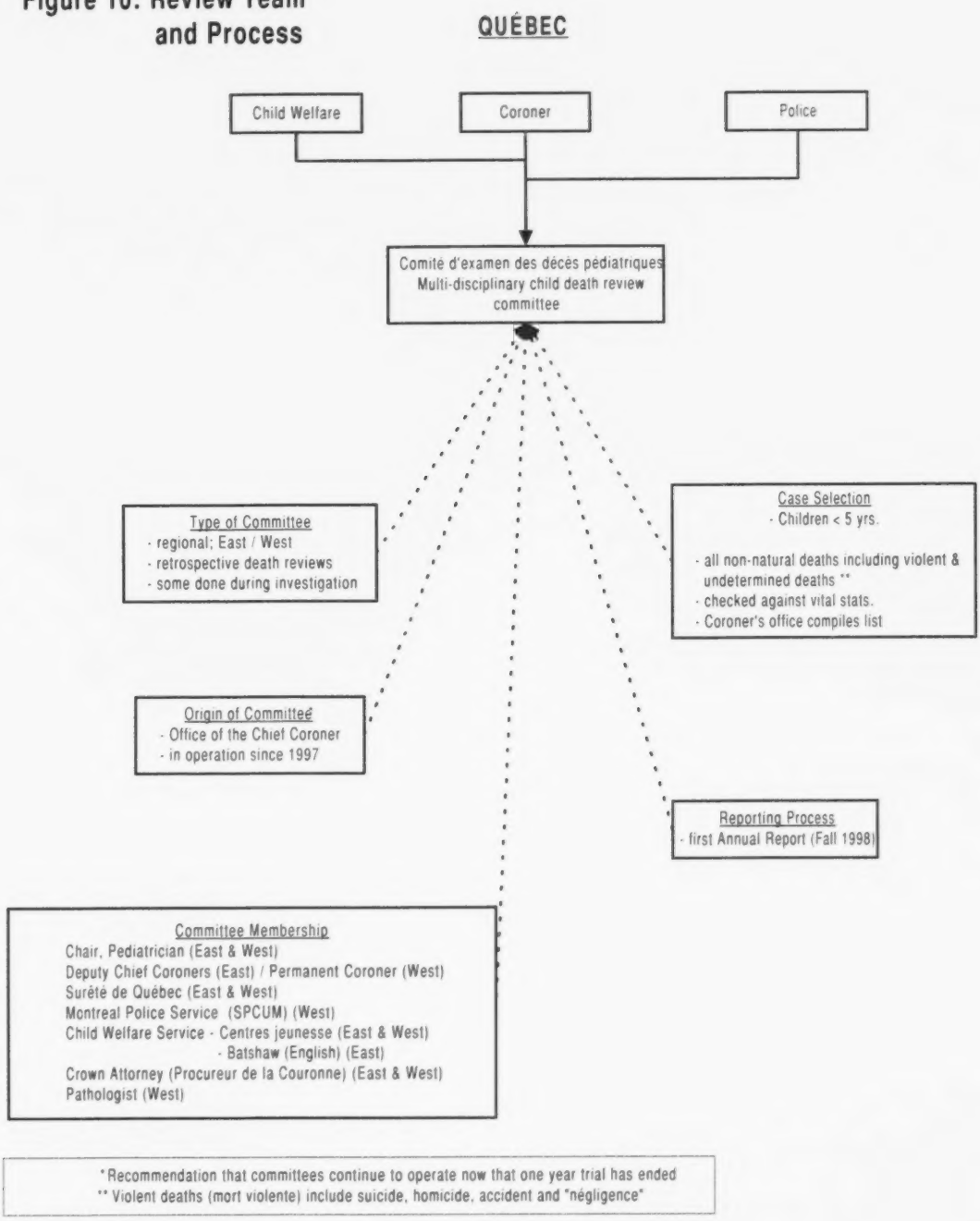

NOVA SCOTIA
Death of A Child
Stage I Notification
Provincial Child Welfare
Chief Medical Examiner
Police
No mandated notification
- all sudden, unexpected deaths (silent on children in care of province)
- suspicious" deaths
All reported child deaths
Stage II Investigation
Children receiving child welfare services or dying of maltreatment
Joint investigation of C.A.N. or suspected C.A.N. deaths
- autopsy "suspicious deaths"
- injury, violence, unwitnessed
- no provincial autopsy protocol
Joint investigation protocol
Stage III Recommendations / Actions
Recommend changes to agencies, gov't. to prevent similar deaths
Lay charges / No further action
Recommend action / no action
- quality assurance
- issues of culpability
Call inquest
Additional options
- further internal review
- notify Deputy Minister
- Minister calls public inquiry (not usual)
Preventable Child Deaths Review Committee
- formed in 1998
- ad hoc, bimonthly meeting
- purpose to develop policy and process for case reviews, data collection, risk assessment, accountability
Dept. of Health
Dept. of Justice
Office of Chief Medical Examiner
Dept. of Community Services / Children's Aid Societies
IWK Grace Health Center

Figure 10: Review Team and Process


QUÉBEC
Child Welfare
Coroner
Police
Comité d'examen des décès pédiatriques
Multi-disciplinary child death review committee
Type of Committee
- regional; East / West
- retrospective death reviews
- some done during investigation
Case Selection
- Children < 5 yrs.
- all non-natural deaths including violent & undetermined deaths **
- checked against vital stats.
- Coroner's office compiles list
Origin of Committee*
- Office of the Chief Coroner
- in operation since 1997
Reporting Process
- first Annual Report (Fall 1998)
Committee Membership
Chair, Pediatrician (East & West)
Deputy Chief Coroners (East) / Permanent Coroner (West)
Surété de Québec (East & West)
Montreal Police Service (SPCUM) (West)
Child Welfare Service - Centres jeunesse (East & West)
- Batshaw (English) (East)
Crown Attorney (Procureur de la Couronne) (East & West)
Pathologist (West)
* Recommendation that committees continue to operate now that one year trial has ended
** Violent deaths (mort violente) include suicide, homicide, accident and "négligence"

the Chief Medical Examiner, the Director of Child Welfare, the Provincial Child Protection Services Coordinator, the Administrator of Family and Children's Services, a representative from the Department of Justice and the Director of Social Work at the Children's Hospital and a pediatric specialist from the Children's Hospital. Nova Scotia will have a Children's Advocate as part of the Ombudsman's Office beginning in 1999. It was not specified if the Advocate will have any role to play with respect to child deaths.

NEW BRUNSWICK

Deaths of Children

In New Brunswick, the death of a child is reported to the Chief Coroner or to the local coroner when the death was sudden or unexpected or was under conditions which the coroner decides may require an investigation into the cause or circumstances of the death.[6] The coroner or the police assisting the coroner under the provisions of The Coroner's Act checks the status of the family with the Provincial Department of Health and Community Services to determine if a report to that department is necessary. Complete autopsies are done for all reportable child deaths and full body x-rays are requested by the Coroner. Toxicology studies are done routinely at the RCMP lab and the province uses four or five pathologists for its child death investigations.

After the autopsy report is complete and other reports have been received, the coroner will decide if an inquest is necessary. While reports on the circumstances of the deceased child are sometimes received from the provincial child welfare department, issues of confidentiality continue to be a concern. The local coroner passes a recommendation for inquest to his or her immediate supervisor. From there, it is reviewed by the department chief then by the Chief Coroner. The Chief Coroner has access to a Coroner's Review Committee, which includes two senior officials from the Coroner's department to provide feedback on contentious cases. Inquests are presided over by a coroner and a five person jury selected from the voters' list.

Investigation of Deaths of Children Known to Provincial Child Welfare Services

The province's Department of Health and Community Services is notified of the deaths of children under the age of 19 years who received child welfare services during the year prior to death. Deaths involving suspicious circumstances, child abuse or the public interest are reviewed at the discretion of the regional director. In cases where the cause of death is not clear, a review is usually done. The internal review is done within 30 days and is forwarded to the central child welfare office and from there to the child death review committee. The focus of the review is on the services provided to the child by the Department. In the future, the child welfare service will be computer networked with public and mental health systems.

The Fredericton Police Department has a Family Services section that deals directly with social services in cases that involve children known to social services. The section is a sub-branch of the police Major Crimes division and is accustomed to working in a team format with other disciplines. Major Crimes investigates all child deaths but deaths of children due to terminal illness or other terminal conditions may not require the same depth of investigation. An internal review is done after child death investigations including a debriefing for investigating officers.

Child Death Reviews

New Brunswick's Minister of Health and Community Services instituted a child death review committee in 1998. A retired judge of the Provincial Court serves as Chairperson and members include a police officer, a pediatrician, a University social work professor and a representative from the Office of the Chief Coroner. The Child Death Review Committee was established by the Minister of Health and Community Services to review the deaths of children under the age of 19 years who have been known to the child welfare system during the year before their deaths. The province's legislation was amended to allow access to documents by the Child Death Review Committee. Reports are written concerning each investigation and recommendations are presented to the Minister responsible for child welfare services. The recommendations that relate to "relevant protocols, policies, procedures, standards and legislation; linkages and coordination of services with relevant stakeholders; and improvements to services for children" are released to the public and the Minister must respond within 45 days.[7] If children do not fall under this mandate, the Office of the Chief Coroner is responsible for reviews of their deaths. Recommendations by the child death review committee and by the Chief Coroner concerning the deaths of children are not binding. The recommendations made by the Chief Coroner are included in the annual report of his office.

NEWFOUNDLAND

Deaths of Children

The interview informant from Newfoundland was a representative of the Royal Newfoundland Constabulary. This police force assists the Chief Medical Examiner in investigating non-criminal child deaths in addition to investigating deaths under the Criminal Code of Canada. Three years ago, the province's system for medical-legal death investigations was reorganized and the position of Chief Medical Examiner was created under The Medical Examiner Act. Deaths involving child abuse must be reported by the police to provincial child welfare authorities. The Constabulary participates with child protection workers in joint child abuse training.

The police do not investigate deaths due to natural causes. Accidental and any suspicious deaths (including SIDS) are investigated for the CME by the Major Crimes unit. The CME determines when autopsies are performed and what tests are necessary. An internal review of the police investigation occurs before the file is closed to ensure that the requirements of policy, procedures and legislation have been met. In the case of homicides, a Crown Attorney and the CME are involved in the case review. The Constabulary is in the process of building a new data management system. The child protection service is more involved than in the past in the joint investigation of child deaths after it was discovered that there was overlap. The informant was not familiar with any move toward multi-disciplinary child death review teams in Newfoundland.

Child Death Reviews

The Chief Medical Examiner's survey response indicated that there is an internal review process for all child deaths. Recommendations are produced after each review with respect to preventing similar deaths in the future. An analysis of child deaths investigated by the Office of the Chief Medical Examiner is currently under review for a peer review publication.

YUKON TERRITORY

Deaths of Children

In the Yukon Territory, the Chief Coroner is notified by the RCMP or hospitals (and Nursing Stations) of the deaths of children. Although no notification is mandated, the Chief Coroner will request police assistance in the investigation and will notify Family and Children's Services in the Department of Health and Social Services to determine if there was any service being provided to the child or family. Under The Coroner's Act, deaths of children due to natural disease or expected deaths where the cause of death is readily known are not reportable. Lay coroners assist the Chief Coroner in fulfilling the mandate of the office. A good working relationship exists between the British Columbia Chief Coroner and the Yukon's Chief Coroner, making consultation on difficult cases readily available.

A decision about whether or not a death may result in criminal charges is made in conjunction with the RCMP. The Chief Coroner does not accept partial autopsies in death investigations. Bodies are sent to Vancouver for autopsy by a forensic pathologist. The British Columbia Children's Hospital performs autopsies according to a protocol that includes a full body x-ray as well as any tests the pathologist believes are necessary. A SIDS protocol is used for autopsies on infants believed to have died as a result of SIDS. The Chief Coroner reviews each case as it is completed and a decision is made about an inquest. The options open to the Yukon's Chief Coroner include a Judgement of Inquiry and an inquest. A Judgement of Inquiry is a "paper inquest" and involves the review of statements and file material by the presiding coroner. Inquests involve a Coroner and a jury that provides recommendations based on the evidence heard. While the Chief Coroner is supportive of the concept of multi-disciplinary fatality review teams, the Yukon's low child death numbers make such reviews impractical.

The RCMP is the police force of the Yukon and assists the Chief Coroner and the territory's lay coroners in child death investigations. The RCMP is notified of all child deaths, including expected deaths although the force does not investigate expected deaths. Deaths are investigated as homicides until proven otherwise. Deaths that appear purely accidental, for example motor vehicle accidents, are scrutinized for any contributing factors. The General Investigation Service (GIS) is available to assist members in small communities but often the size of the community (towns of 200 to 300 residents are common) works in the investigator's favour in discovering the facts of the case. At the completion of a child death investigation, the detachment commander or the GIS commander reviews the file. The force's protocols for assisting the Chief Coroner have been streamlined. However, if the Chief Coroner asked that particular steps be taken during, for example, a SIDS investigation, the force would make every effort to accommodate the request. The RCMP did not see any immediate need for any other review mechanisms, as there is a good working relationship between the Department of Health and Social Services, the Department of Education, The Chief Coroner and the RCMP.

The Yukon does not have a multidisciplinary child death review body.

NORTHWEST TERRITORIES

Deaths of Children

The Northwest Territories (NWT) uses a system of lay coroners to investigate child deaths reported to the Chief Coroner. The service is linked with the Office of the Chief Medical Examiner in Alberta for technical support. The Coroner's Act defines reportable cases as sudden and unexpected deaths while fatal disease and expected deaths are not

reportable. The police and hospitals (or Nursing Stations) notify the Chief Coroner of deaths. While it is not mandated, the coroner checks with the Department of Health and Social Services to determine if that department is involved with the family. If this is the case, the file may be discussed with a view toward preventing similar deaths in the future. The coroner's investigation determines the W5 (Who, What, Where, When, Why) of the child's death. A forensic pathologist in Alberta does autopsies for the Coroner of the NWT. If there were a compelling reason, a child could be autopsied by a forensic pediatric pathologist in either Winnipeg or Toronto but logistics of this are quite difficult. (The impact on the Coroner's service of the impending division of the NWT into an eastern and a western territory was not discussed.)

In concluding a review of a death, the Coroner issues a Coroner's Report. If more depth is needed, a Judgement of Inquiry takes place and a report and recommendations are made public. An inquest provides the Coroner with a jury verdict and recommendations.

Child Death Reviews

The NWT has a multi-disciplinary Childhood Fatality Review Committee that meets periodically to review child deaths of children between the ages of 8 days and 16 years using information from Vital Statistics, the Department of Health and Social Services, the Coroner's Office and the RCMP. While it is not a mandated committee, deaths are routinely reported by the Chief Coroner to the committee. The Coroner also notifies the territorial child welfare system of any child deaths involving its client families. The Chief Coroner believes that the review committee process is useful but felt that a full-time case coordinator for the committee would be beneficial for continuity. The small number of cases for review results in meetings on a bimonthly basis.

The NWT Department of Health and Social Services Consultant on Child Abuse Prevention attends the Child Fatality Review Committee on behalf of the Superintendent of Child Welfare. Representatives from the regional hospital and the NWT Registered Nurses' Association also attend as does the Chief Medical Officer of Health and the Chief Coroner. If the death is a suicide, the mental health service is notified. The committee does not conduct its own investigations but relies on coroners' reports for information on the circumstances of the deaths reviewed. The majority of children under the age of 16 years whose deaths are reviewed have been autopsied. The Committee focuses on whether appropriate policies were followed concerning services provided to the child. The Committee has issued a brief statistical report, but it is too early for any trend analysis. The consultant believes that such reviews are an excellent idea.

Review Teams and Processes

An overview of child death review teams in Canada is contained in Table 1. Responses from both survey and interview material were used.

With respect to the operation of child death review processes in provinces and territories, the systems for child death review currently in use in British Columbia, Manitoba and Nova Scotia are diagrammed in Figures 7 through 9. British Columbia's child death review process is unique in its use of a Commission as the means of conducting child death reviews (in addition to the other work of the Commission). Manitoba's process illustrates a well-established committee with strong links with the provincial child welfare system. Manitoba's unique feature is a

mandated review by the CME of the services provided both by the province's child welfare directorate and the child welfare agency involved with the deceased child and family. This results in a confidential report to the Minister of Family services. Legislative change is being contemplated to allow the CME to release recommendations made to the Minister of Family Services in a non-identifying format in the CME's Annual Report. Nova Scotia's review process is in the developmental stage and its review team is engaged in defining and setting up the process for future reviews. Quebec's multidisciplinary child death review committee is included in Figure 10 as an example of a regional committee structure.

VI CONCLUSIONS

The Provinces and Territories surveyed were receptive to receiving and exchanging information about child abuse and neglect deaths in order to determine the scope of this problem across the country. The proposal that efforts be made to establish common definitions and categories of identification as well as sharing of selected data nationally received the support of respondents across the systems and jurisdictions surveyed. It was suggested that national meetings of Chief Coroners and Chief Medical Examiners might provide a "home" for such review teams to work together at a national level.[8]

Child Death Review Teams (CDRT) in Canada are organized to perform differing functions; to serve as 'watchdogs' over other government departments through quality assurance reviews or to provide multidisciplinary reviews by agencies and government departments either at the conclusion of cases or while a death is being investigated. These CDRT's also may recommend changes in government policy or to legislation based on areas of need identified during reviews. Teams also can function as a resource to those agencies or government departments charged with investigating and

Table 1 **Multi-Disciplinary Child Death Review Teams Across Canada**

Functions	BC	Alberta	Sask.	Manitoba	Ontario	Quebec	N. Scotia	N. Brunswick	P.E.I	Nfld.	Yukon	NWT
Multi-disciplinary child death reviews	Yes	No	Yes	Yes	Yes	Yes	Yes[1]	Yes[1]	X	No	No	Yes
Legislative mandate for review process	Yes	n/a	Yes	No	No	No	No[2]	No[2]	X	n/a	n/a	No
Case review function	Yes	n/a	Yes	Yes	Yes	Yes	No	Yes	X	n/a	n/a	Yes
Policy development	No	n/a	Yes[3]	No	No	No	Yes[4]	Yes	X	n/a	n/a	u/k
Provincial/Territorial child welfare membership	No	n/a	Yes	Yes	No[5]	Yes	Yes	No	X	n/a	n/a	Yes
Recommendations released case by case	Yes	n/a	Yes	No	No	No	No	Yes	X	n/a	n/a	No
Annual Report release of recommendations	Yes	n/a	Yes	Yes	Yes	No	Yes[6]	u/k	X	n/a	n/a	No

[1] Formed in 1998
[2] Ministerial terms of reference
[3] Separate committee
[4] Preparing for future case review committee
[5] Ont. Assoc. of Children's Aid Societies involved
[6] Future release
X No reponse received at time of printing

responding to child maltreatment deaths. In Canada, there are mandated CDRT's in addition to ad hoc CDRT's that have formed in the offices of Chief Coroners or Chief Medical Examiners. Ensuring that teams are independent of outside influence was a concern for respondents as was a mandate that provided access to the information necessary for a complete and thorough investigation. In addition, it was felt that there should be a means of providing annual reports for public release.

Canada's ability to submit its child abuse and neglect fatalities to detailed, retrospective analysis is hampered as there is no uniform national coding system that permits the creation of a database comprised of these cases. Canada has no national statistics on neglect deaths and there is no standardized definition of fatal neglect either in law or practice. Provincial and territorial child welfare legislation varies in its definition of neglect (or contains no definition at all). If efforts are made to ensure that maltreatment deaths are retrievable from provincial or territorial databases, risk assessment and the prevention of future deaths will be enhanced by an improved understanding of the circumstances and characteristics of these deaths.

Currently, homicides of children are entered into the Statistics Canada mortality database based on information abstracted from death certificates. It is believed that these numbers are an underestimation of the true incidence of child homicides. The Homicide Survey database maintained by the Canadian Centre for Justice Statistics tracks ongoing homicide investigations. All police forces in Canada are required to report cases when a police investigation is initiated. (Health Canada, 1997, p. 254) The Homicide Survey provides more detail on the circumstances of death than does the mortality database. Despite this, the Homicide Survey may miss cases classified as homicides by a pathologist, coroner or medical examiner, whose determination will be based on reasonable medical probability, if there is no corresponding police investigation. Data from coroners or medical examiners across Canada is potentially a rich information source and would allow a comparison between Homicide Survey rates and rates from coroner and medical examiner data.

While a national strategy on data collection remains a necessity, the data collection process would be more cost effective if it were based on a system of data extraction from existing databases.[9] This would require achieving agreement across provinces and territories as to which data elements are necessary in order to perform meaningful data analysis on maltreatment deaths. Common definitions would allow uniform coding of data. Existing databases could be altered to allow collecting and coding of information on, for example, whether the child was supervised at the time of death, whether alcohol was used by caregivers within a particular time period before the child's death, socio-economic conditions, involvement with child welfare agencies, etc. The need for funding for training at the provincial or territorial level was mentioned as a consideration in establishing any national database.

Using a system such as the International Classification of Diseases, Version 10 (ICD-10) carries with it the problems associated with "losing" data that does not fit the data fields. It may be possible to build a system that incorporates the ICD-10 yet allows a richer capture of data. For example, a case in which a child dies in a car-pedestrian accident while being escorted across the road by an adult is qualitatively different than a case in which a

chronically unsupervised child is struck by a car while crossing a busy street alone. For coding purposes, the manner and cause of death are the same but the circumstances are quite different.

During interviews with survey respondents, the researchers asked about a "wish list" for a national database of information based on reviews of child deaths. Evaluation of the impact of specific risk factors, including substance abuse, domestic violence and previous child abuse would make it possible to compile a profile of families at risk for fatal or severe abuse or neglect. (Durfee et al, 1992) There would also be the benefits derived from identifying trends, comparing data across the country by geography; such a database could be more than a "data receptacle". Common definitions of terms and a common database were frequent suggestions. The issue of common definition has a history in the child welfare literature as a barrier to data collection and to meaningful comparison of rates of child maltreatment. The United States has struggled with this issue in its attempts at national surveys of child abuse and neglect (and child death) rates. Canada has a greater possibility of success due to the smaller number of jurisdictions to consider; 13 provinces and territories versus 50 states.

A suggestion that was made a number of times was that there be an "expert" component included—either on-line consultation via the Internet or access to an on-line archive of literature on injuries, advances in forensic science and investigative techniques. Another request was that any system be user-friendly in order that data entry is as uncomplicated as possible and queries can be made easily by system users. Some respondents wanted to know more about the perpetrator in an effort to understand the "why" of child maltreatment deaths. Others wanted to know about the family compositions and risk factors most commonly found with particular child deaths.

Early detection of families at risk for fatal child abuse or neglect is necessary if these deaths are to be prevented. Multi-disciplinary interventions can ensure that children do not fall through cracks in provincial, territorial and national systems for serving families and protecting children. Child death review teams provide opportunities to understand child maltreatment deaths through case specific reviews and, of equal importance, to build relationships that will enable communities to better serve these families. (Granik, 1991) Team members benefit from the information provided during child fatality reviews and also from an enhanced awareness and education on managing difficult cases and preventing child deaths. Such reviews improve data collection and quality assurance in child death investigations at local and provincial levels and aid in the more accurate identification of risk. factors associated with fatal child maltreatment. Reducing preventable or "accidental" deaths is also possible when the review process identifies opportunities to direct prevention efforts where they will have the most benefit.

END NOTES

1 A total of 90 surveys were mailed out; some were duplicated within provinces and systems leaving 79 surveys when these were removed. Forty-six surveys were returned.

2 The British Columbia Children's Commission has been included among the Child Advocates for purposes of data analysis. Its unique mandate and origins were judged by the researchers to be unlike those of traditional child protection systems. The following provinces have Child Advocates: British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, and Quebec. Nova Scotia will have a Child Advocate in 1999.

3 Report of the Gove Inquiry into Child Protection in British Columbia, 1995.

4 Saskatchewan Children's Advocate Report, *Child Death Review, Karen Rose Quill*, June 1998.

5 Ibid., p. 10.

6 Coroners Manual, Province of New Brunswick, June 1995, Topic 1.110.

7 Child Death Review Committee, Terms of Reference, Minister of Health and Community Services, New Brunswick, January 1998.

8 Our thanks to Cathie Halpenny, Legal counsel, Office of the Chief Coroner of Quebec for suggesting the annual meeting as an appropriate "home" for this working group.

9 Our thanks to Peggy Justason, Policy Analyst, Office of the Chief Coroner of British Columbia, for her comments and clear thinking on this issue.

APPENDIX A

Project Advisory Committee

The Advisory Committee to the Child Mortality Analysis Project is a multi-disciplinary committee of professionals involved in child death reviews. The membership includes (in alphabetical order):

Mr. Larry Campbell, Chief Coroner, Province of British Columbia

Dr. Graeme Dowling, Chief Medical Examiner, Province of Alberta

Dr. Michael Durfee, Child Abuse Prevention Program, Department of Public Health, County of Los Angeles, California, USA

Dr. Peter Markesteyn, Chief Medical Examiner, Province of Manitoba (on sabbatical leave, July 1, 1998 to June 30, 1999)

Ms. Sandy Moshenko, Accreditation Manager, Ontario Association of Children's Aid Societies

Mr. Gordon Phaneuf, Chief, Child Maltreatment Division, Bureau of Reproductive and Child Health, Health Canada

Mr. George Savoury, Director of Child Welfare Services, Province of Nova Scotia

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